California MEDICINE

JULY 1950

What's New—*A Panel Discussion*

C.M.A. House of Delegates Proceedings—Page 73

OFFICIAL JOURNAL
OF THE CALIFORNIA MEDICAL ASSOCIATION

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California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 73 JULY 1950 No. 1

What's New in Thyroid Surgery

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ALTHOUGH relatively little new data have been developed during the past several years regarding the etiology of hyperthyroidism, enormous strides have been made in the treatment of the disease. In spite of the great progress made in methods of treatment, controversy still exists as to the preference for types of treatment. Three major types of therapy—(1) subtotal thyroidectomy, (2) antithyroid drugs, and (3) radioactive iodine — are being utilized today. Since favorable results are reported with all three of these different forms of treatment, it is obvious that it will require several more years' study before decision as to which is the best can be reached. However, there is already enough information about all three to suggest that one method of treatment may be superior in a certain group of patients and one of the others superior in another group. It is very probable that the greatest problem in this field during the next few years is going to be to decide the boundary lines of groups of patients in whom one method is better than another.

DIAGNOSIS OF HYPERTHYROIDISM

The diagnosis of hyperthyroidism is really outside the limits of this presentation. However, since differential diagnosis is so important in deciding whether or not specific therapy is necessary, it may be well to comment on two or three important points in differential diagnosis of the doubtful cases. In the first place, administration of Lugol's solution over a period of several days is of extreme value in establishing the diagnosis in doubtful cases, insofar as the drug produces a sharp improvement in symptoms within six to ten days if the manifestations are produced by hyperthyroidism. During the past two or three years it has been shown by several workers that the administration of radioactive iodine may be very helpful in establishing a diagnosis, but unfortunately there is a great variation in methods reported. In the method reported by Werner and associates[10] a dose between 40 and 100 microcuries is given to the patient and radioactivity in the thyroid measured with a Geiger counter, placed at a standard distance of 15 cm. from the neck, with the isthmus of the thyroid identified as the center of the field. The measurements are taken at the end of 24 hours. These investigators studied 57 patients with euthyroidism. The radioiodine uptake by the thyroid at the end of 24 hours ranged between 7 and 49 per cent of the tracer dose given. In this group 91 per cent of the patients had thyroid uptake below 35 per cent. The same investigators studied uptake in 97 patients with hyperthyroidism. In 94 per cent of this group the uptake exceeded 35 per cent. It is very significant that in a series of 21 patients studied following thyroidectomy with good results and return of basal metabolic rate to normal, 38 per cent showed uptake above 35 per cent. In 44 patients with nontoxic diffuse or nodular goiter, the uptake was the same as in the normal individuals. In acute thyroiditis the uptake was low, but in chronic thyroiditis it was low in only one of the 17 patients in whom the test was performed. In carcinoma of the thyroid the uptake was normal in the nine patients studied.

Studies on the amount of protein-bound iodine following ingestion of radioactive iodine for diagnostic study will add to the accuracy of the test. For example, 24 hours after ingestion of radioactive iodine, McConahey and associates[6] found that 75 per cent or more of the iodine was present in the protein-bound form in hyperthyroid patients. In euthyroid persons, the iodine 24 hours after ingestion was found in the protein-bound form in quan-

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Guest speaker's address. Presented before the Third General Meeting as part of the Panel Discussion on What's New in Medicine at the 79th Annual Meeting of the California Medical Association, San Diego, April 30-May 3, 1950.

tities less than 45 per cent. In one patient with myxedema, the amount of protein-bound iodine found 24 hours after ingestion of radioiodine was too small to be measured.

TREATMENT BY THYROIDECTOMY

Cattell[2] of Boston has adequately summarized the results with subtotal thyroidectomy. In reporting on a study of 1,630 patients observed between 1943 and 1949 at Lahey Clinic, he noted that relief of symptoms was obtained permanently in 90 to 95 per cent of patients. The operative mortality rate in this group of patients was 0.24 per cent. In a closer analysis of the first 1,000 consecutive patients in this series, he noted that postoperative complications were encountered with an incidence indicated in Table 1.

TABLE 1.—*Surgical Treatment of Hyperthyroidism*
SUMMARY—1,000 CONSECUTIVE PATIENTS
(After Cattell, in Tr. Amer. Goiter Assn., 1949)

	Per cent	
Hemorrhage	2.7	
Tracheotomy	1.3	
Postoperative hypothyroidism	4.5	
		8.5
Tetany	1.5	
Nerve injury	1.0	
Recurrence	2.4	
Mortality	0.2	
		5.1

In the series reported by Cattell, all patients were prepared preoperatively with one of the antithyroid drugs, most recently propylthiouracil.

There is not total agreement regarding the use of these drugs supplementing surgical therapy. However, it is the author's opinion that preparation of patients with propylthiouracil before thyroidectomy will result in a much lower mortality rate. It is his custom to treat all patients with hyperthyroidism with propylthiouracil. As will be discussed later, a small number of this group, including those with small glands, symptoms of recent origin, and those with mild toxicity, have been treated for a long period of time in the hope that permanent remission might be obtained with medical treatment. Propylthiouracil is given until the patient's basal metabolic rate approaches normal. In that group in which resort to thyroidectomy has been decided upon, Lugol's solution is then started. After 12 to 15 days of treatment with Lugol's solution, the propylthiouracil is discontinued. Four to six days later operation is performed.

All surgeons agree that treatment with antithyroid drugs increases vascularity of the gland, although this increase in vascularity is disturbing to the surgeon in only a small percentage of cases. Preliminary ligation of the inferior thyroid artery (i.e., at the time of operation), as practiced by many surgeons, will prevent significant bleeding. In the author's opinion, utilization of propylthiouracil in preparation of patients for thyroidectomy will lower the mortality rate following operation. Because of the low mortality rate following thyroidectomy, it will take a very large series of cases to prove this point. In over 1,000 patients having thyroidectomy during the ten-year period between 1936 and 1946 at Illinois Research Hospital, the mortality rate was slightly less than 1 per cent. However, during the past three to four years when antithyroid drugs have been used in preparing patients for thyroidectomy there have been no postoperative fatalities in perhaps 300 thyroidectomies.

TREATMENT WITH ANTITHYROID DRUGS

In an attempt to obtain thorough evaluation of the antithyroid drugs, Astwood[1] has adopted the principle of using this method to the exclusion of others. Although propylthiouracil is the drug of choice, Astwood reports fairly effective results following the use of methylthiouracil and mercaptoimidiazole. During the past few months the present author in association with Fowler and Heidenreich has used another drug, iodothiouracil, in about 25 patients. Utilizing the dose of 150 mg. daily, as originally suggested for this drug, satisfactory results in reduction of hyperthyroidism were obtained in no more than 50 per cent of patients. However, with twice or thrice that dose fairly effective results have been obtained, although as yet no advantage of this drug over propylthiouracil has come to light. It was thought originally that this drug might have a more rapid effect than the other antithyroid drugs.

In an analysis of 300 patients given propylthiouracil over a four-year period, Astwood noted that with the dosage of 150 mg. a day about 20 per cent of patients did not respond properly. However, when this dose was increased to 300 mg. a day, response was satisfactory in all but 4 per cent. The present author, as well as others, has had the same experience, namely that with proper dosage of propylthiouracil very few patients will fail to be relieved of hyperthyroidism. As to patients treated with propylthiouracil as a major form of treatment, Astwood reports that detailed data are available on 137 who were treated for a prolonged period of time. Of this group 62 per cent obtained permanent remission, which at the time of his report was of six months' to three years' duration. If the patient is going to have a recurrence of hyperthyroidism following cessation of the drug therapy, symptoms usually will be shown within two months. With the increasing passage of time beyond this period with freedom from symptoms, there is a decreased incidence of relapses. However, patients may be free from symptoms for as long as two to three years and then have recurrence of symptoms.

At Illinois Research Hospital a small group of patients with symptoms of short duration or with small glands or with mild symptoms of antithyroid therapy alone was studied. These patients were treated for six to eight months with the drug before therapy was stopped, and 35 to 40 per cent of them

had remission. However, this represents a picked group of patients and these figures cannot be looked upon as an index of the effect of the drug in all patients with hyperthyroidism.

TREATMENT WITH RADIOIODINE

Soley[8] in an article published in 1949 analyzed results of the use of radioactive iodine in 288 patients with hyperthyroidism in numerous clinics throughout the country. One of the greatest difficulties in the use of radioactive iodine is in the inability to establish a given dose for the patient. It is well known that in general the amount of iodine required is related to the weight of the gland. After experimenting with doses of various sizes, most workers have found that a dose of 100 micrograms of radioiodine per gram of thyroid tissue will eliminate hyperthyroidism in the majority of patients. However, Soley reported that the reaction was quite inconsistent in that some patients were relieved of symptoms with as little as 23 micrograms of radioiodine per gram of thyroid tissue, whereas others required as much as 575 micrograms. In the series analyzed, at least two patients became myxedematous with less than 50 micrograms per gram of thyroid tissue.

In the series of cases analyzed by Soley, the estimated average weight of the thyroid before treatment was 43 gm. After treatment, the weight of the thyroid was estimated at 20 gm. The average time required for the return of the basal metabolic rate to normal was slightly less than five months. A major complication was postoperative hypothyroidism or frank myxedema, which occurred in 8.5 per cent of patients.

In the 288 patients treated with radioiodine there were five deaths, which is approximately the same mortality rate as occurs in subtotal thyroidectomy. It might be said that it is unfair to attribute deaths in this series to the therapy, since two of these patients died of myocardial infarction, two died of vascular accidents of the brain and one died of cardiac failure. It might likewise be stated that at present practically all postoperative deaths following thyroidectomy are of the same type, namely cardiac or apoplectic. Accordingly the mortality rate largely relates to the normal death rate occurring over the period when therapy is being undertaken. Under such circumstances the figures would be unfair to treatment with radioiodine, since the patients being treated are observed over a period of four to six months, whereas patients after operation are held in the hospital no longer than six to ten days.

Of the 288 cases studied by Soley, results were good in 83 per cent and fair in 9.7 per cent. In 5.5 per cent, failure was reported.

Werner and associates[10] also noted that the initial dose of radioiodine is adequate in only about two-thirds of patients. They called attention to the fear expressed by many investigators that carcinoma might develop in these glands years later. The basis for this fear is related to the fact that radio-autography shows an irregular collection of iodine in the glands. If iodine is concentrated in certain areas of the gland, it is conceivable that damage leading to anaplastic changes might take place. It would appear that 15 or 20 years might be required for this transformation. Accordingly, many workers have reserved treatment with radioiodine for patients in the older age groups.

The treatment with radioiodine might be summarized by saying that the drug is effective alone in hyperthyroidism, but that the dose required is inconsistent. Because of the slight danger of production of anaplastic changes years after therapy, it would presumably be desirable, for the present, to confine use of the drug to people in the later decades of life. There appears to be strong indication for its use in recurrent hyperthyroidism following thyroidectomy since the drug will be effective in 90 per cent of such cases, whereas a second operation is effective in little more than 50 per cent of patients with recurrence. Patients with parathyroid deficiency or recurrent laryngeal nerve damage would likewise be good candidates for radioiodine therapy rather than operation. Opinions differ as to the preference in elderly people with cardiac failure. In general, toxic nodular goiter should not be treated with radioiodine except in the circumstances previously mentioned.

CARCINOMA OF THE THYROID

There is considerable difference of opinion as to the incidence of carcinoma of the thyroid, largely because of the difficulty in making a diagnosis from the microscopic slide and because of the great variation in the degree of malignancy. There is no doubt that several years ago the diagnosis of carcinoma was made too often. It is barely possible that the extreme caution in diagnosis urged by pathologists throughout the country during the past few years has swung the pendulum to the other side, and that now the diagnosis is not made often enough. For example, a patient recently admitted to the Illinois Research Hospital had had thyroidectomy 20 years previously, with a diagnosis of nontoxic nodular goiter. There was a nodule in the anterior portion of the neck which, upon histologic examination, turned out to be carcinoma of the thyroid. Further exploration revealed metastatic nodules in the left side of the neck occupying the region from which the thyroid lobe had been removed. There was actually no remnant of the thyroid lobe left on this side, indicating that the tumor could not have been a new tumor of recent origin. This prolonged survival is not unique; investigators have observed many patients for years with metastases changing very little over the course of several years.

The controversy regarding the exact origin of aberrant goiter has been crystallized considerably during the last few years. It is now fairly well agreed that aberrant thyroid nodules are in reality metastatic lymph nodes. It has been shown by many workers that if the ipsilateral thyroid lobe is removed and examined carefully by serial section, the primary lesion can be found with practically no ex-

ceptions. The degree of malignancy in aberrant goiter is actually less pronounced than in the usual type of carcinoma of the thyroid, as has been emphasized by Ward[9] and others.

As has already been indicated, considerable difference of opinion exists relative to the incidence of carcinoma of the thyroid. In some studies conducted at the Illinois Research Hospital six years ago, Cole and associates[3] noted that carcinoma was present in 17.1 per cent of their patients having thyroidectomy for nontoxic nodular goiter. This figure appeared remarkably high, but this was perhaps the first time that the incidence of carcinoma was studied in relation to the various types of goiter. In that series the percentage of carcinoma in toxic nodular goiter was only 1.2 per cent, and in toxic diffuse goiter it was only 0.2 per cent. Since that series was small, the author again reviewed his case records in 1948, but found approximately the same incidence (namely 17.2 per cent) of carcinoma in nontoxic nodular goiter (see Table 2).

Table 3 illustrates the incidence of carcinoma in various types of goiter, as obtained from reports in the literature. In addition to the figures shown in Table 3, Cope and associates have reported an incidence of 10 per cent carcinoma in all nodular goiter, and 19 per cent in goiters consisting of single nodules. Accordingly, it appears than when detailed studied are made of a large series of patients operated upon for goiter, a high incidence of carcinoma is found in patients with nontoxic nodular goiter. It is appreciated by all workers that nontoxic nodular goiter in children is associated with perhaps a still higher incidence of carcinoma, varying between 20 and 40 per cent in different localities.

It is perhaps true that carcinoma of the thyroid is, to some extent, a geographic disease insofar as goiter itself is a geographic disease. The exact role of geography is not fully understood in the incidence of carcinoma.

TREATMENT OF CARCINOMA

Although controversy likewise exists as to the treatment of carcinoma, during the past few years certain points have crystallized from the mass of indeterminate data. Some of the difficulty in arriving at an opinion as to the best form of treatment lies in the fact that so many different types of therapy are available and are being used. For example, carcinoma of the thyroid is being treated by (1) subtotal thyroidectomy, (2) total thyroidectomy, (3) radical resection of the neck, (4) x-ray therapy, (5) radium therapy (radon seeds), and (6) radioactive iodine. Most workers will agree that the tumor should be removed if possible, largely because it has now been demonstrated that carcinoma of the thyroid will take up significant quantities of radioactive iodine in only about 10 per cent of cases. The treatment of metastatic carcinoma of the thyroid with radioactive iodine has been discouraging but has received renewed support by Rawson and associates,[7] who discovered that total destruction of the thyroid increases the uptake of radioiodine by the metastatic nodules. For example, in eight of 13 cases of adenocarcinoma, the tumor assumed the capacity to concentrate radioactive iodine after the thyroid was removed. The time required for these changes to take place varied between one and 32 months. In one case in which the patient had a solid adenocarcinoma, a metastatic tumor which did not take up iodine even after development of myxedema, was found to concentrate iodine after the patient was given thyroid-stimulating hormone (Armour's thyrotropic hormone). In four

TABLE 2.—*Incidence of Carcinoma in Nodular Goiter (Including Toxic, Nontoxic and Carcinoma) at the Illinois Research Hospital 1936-1948*
(After Cole and Associates, Tr. Amer. Goiter Assoc., 1949)

	1936-1944		1944-1948		1936-1948	
Type of goiter	No. of Cases	% Carcinoma	No. of Cases	% Carcinoma	No. of Cases	% Carcinoma
Toxic nodular	330	1.2	48	0	378	1.0
Solitary	(71)	0.0	(17)	0	(88)	0.0
Multinodular	(259)	1.6	(31)	0	(290)	1.4
Nontoxic nodular	192	17.1	93	17.2	285	17.15
Solitary	(92)	(24.0)	(51)	(25.5)	(143)	(24.4)
Multinodular	(100)	(11.0)	(42)	(7.1)	(142)	(9.8)
Total	522	7.2	141	11.3	663	8.0

TABLE 3.—*Incidence of Carcinoma in Nodular Goiter as Obtained from Numerous Reports in the Literature*
(After Cole and Associates, Tr. Amer. Goiter Assoc., 1949)

Author	No. of Patients with Nod. Goiter (Toxic and Nontoxic)	Per Cent Carcinoma in Nod. Goiter (Toxic and Nontoxic)	No. of Patients with Nod. Nontoxic Goiter	Per Cent Carcinoma in Nod. Nontoxic Goiter	Per Cent Carcinoma in Solitary Nontoxic Nodular Goiter
Brenzier & McKnight (6); Charlotte, N. C., 1940	2,324	4	.....	.....	.....
Horn & Assoc. (7); Philadelphia, Pa., 1947	1,135	6.3	637	9.8	.....
Crile: Cleveland, Ohio, 1948	537	5.6	274	10.9	24.5
Ward: San Francisco, 1947	3,539	4.8	.....	.....	15.6
Cole & Assoc.: Chicago, Ill., 1948	663	8.0	285	17.1	24.4

patients with papillary adenocarcinoma, Rawson and associates found no increase in concentration of iodine in the metastatic lesions after removal or destruction of the thyroid lobe. However, since surgical removal or destruction of the thyroid with radioactive iodine is fairly effective in increasing the uptake of iodine by the metastatic nodules in a large percentage of patients, it appears that this procedure should be resorted to in every operable case. The only point of indecision will lie in whether the remaining thyroid should be removed surgically or destroyed with radioactive iodine. At present there is no consensus on that point although there might be some advantages to surgical removal.

As stated previously, there is a difference of opinion regarding the type of operation to be performed for carcinoma of the thyroid although most workers will agree that the tumor should be removed if possible and perhaps treatment given later with radioactive iodine and/or x-ray therapy. Some surgeons are of the opinion that if the tumor is small and located deep within the body of the thyroid lobe, subtotal thyroidectomy may be sufficient. However, as more experience accumulates with carcinoma of the thyroid, the author is inclined to be more and more radical. For example, during a subtotal thyroidectomy eight years ago, a small tumor was found deep in the body of one lobe. After considerable debate at the time, it was decided not to remove the entire lobe, although the amount of tissue left in place was no more than 3 gm. on the posterior capsule. However, a few months ago the patient returned with a large recurrence in the remnant of the thyroid and numerous metastatic nodules including invasion into the jugular vein. Of course it must be admitted that this recurrence might have taken place even though a total thyroidectomy on that side with a radical excision had been done. The case of another patient, previously referred to in this presentation, may illustrate the advisability of radical resection. Thyroidectomy had been done 20 years previously and on admission to the Illinois Research Hospital a few months ago the patient had a mass in the anterior portion of the neck which proved to be carcinoma. Further exploration revealed several metastatic nodules in the left side of the neck, but no remnant of thyroid tissue. It is apparent that 20 years ago the surgeon removed the right lobe completely. Again, it cannot be said whether or not radical resection would have cured this patient. However, since radical resection for carcinoma of other organs has been accepted without question, it would appear to the author that the same philosophy should be applied in carcinoma of the thyroid gland.

Perhaps this preference for radical therapy has been influenced by the fact that of 16 patients with carcinoma of the thyroid observed by the author during the past four years, 11 are already dead. It should be stated, however, that in about one-half of the 16 cases the lesions were inoperable when the patients were first observed.

THYROIDITIS

Acute thyroiditis. The need for surgical treatment of this condition is dependent upon the causative factor, as indicated by whether suppuration does or does not develop. In practically all cases in which there is suppuration the disease is pyogenic (streptococcus or staphylococcus, more commonly the former). In the author's opinion, at least some of the cases not proceeding to suppuration are viral in origin. This statement is based on the fact that a large percentage of patients with acute nonsuppurative thyroiditis give a history of having had upper respiratory infection a few days before thyroiditis developed; it is fairly well agreed that many of these respiratory infections are viral in origin. Nonsuppurative thyroiditis runs its course within a few weeks and, with the exception of a few of the more severe cases, all symptoms subside within that time. In general, no therapy has been of significant value in such cases, although some clinicians have gained the impression that thiouracil compounds hasten recovery. Certainly operation is not indicated. On the other hand, surgical incision of the fluctuant area is indicated in treatment of suppurative thyroiditis.

Chronic thyroiditis (Hashimoto's disease and Riedel's disease.) The cause of these two lesions is still more obscure than that of acute thyroiditis. However, a fair amount of evidence is available to the effect that infection is not the cause in either of the two. One point is fairly certain, namely, that acute thyroiditis is not followed by chronic thyroiditis of the types just referred to. A few workers have suggested that Hashimoto's disease is an early stage of Riedel's disease, but during the last two or three years there has appeared to be a growing conviction that the two lesions do not represent stages in the same process, but are two separate entities. The fact that Hashimoto's disease is always bilateral and Riedel's disease commonly unilateral supports the idea that the former cannot be the precursor of the latter.

Hashimoto's disease. Although it is fairly well agreed that thyroidectomy should be done in treating this disease, there is no agreement as to how much thyroid should be removed. This indecision is accentuated somewhat by the fact that at times the disease is accompanied by mild hyperthyroidism at the onset. Unfortunately the diagnosis of Hashimoto's disease can rarely be made clinically. Often, indeed, the diagnosis is not made until the tissue is examined microscopically. Davison and Letton[5] noted that following total thyroidectomy mild myxedema developed in 61.5 per cent of 28 patients observed by them. Hypothyroidism occurred in 89 per cent of the total number of cases. Obviously, total thyroidectomy should give rise to a high incidence of hypothyroidism. Some workers believe that Hashimoto's disease is best treated by x-ray therapy, particularly since the incidence of hypothyroidism will be lower with this treatment than after total thyroidectomy. It is barely possible that if a way to select the patients were known, thyroidectomy

might not be necessary in a certain percentage of cases. However, when symptoms of hyperthyroidism are present or when compression symptoms are significant, either subtotal thyroidectomy or irradiation would appear to be strongly indicated.

Riedel's disease. As in the late stages of Hashimoto's disease, hypothyroidism is usually present in woody thyroiditis or Riedel's disease. The gland in this condition is so firm that it is readily confused with carcinoma. One important aid in differentiation is the fact that in carcinoma the basal metabolic rate is usually normal or slightly elevated, whereas in Riedel's disease it is usually below normal, particularly in the latter stages when induration is pronounced. Another point of differential value lies in the fact that if nodes are palpable alongside the thyroid, the diagnosis of carcinoma can usually be made safely, since nodes are seldom involved in Riedel's disease.

Theoretically, removal of the thyroid gland in this condition would be undesirable since it might increase the hypothyroidism. However, there is fairly strong evidence that the thyroid in Riedel's disease is exerting little or none of the function ascribed to the normal thyroid gland.

Since symptoms of compression are so common in woody thyroiditis, thyroidectomy is usually advisable. However, there is little or no justification for attempting to be radical in removing the lobes, particularly since adhesions are frequently so dense and landmarks so obscured that even subtotal resection would seem dangerous to vital structures, the laryngeal nerves in particular. Moreover, it has been discovered that removal of the isthmus and the anterior portion of the thyroid on each side (if both sides are involved) is sufficient to eliminate the compression symptoms.

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What's New in Cardiovascular Surgery

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SUMMARY

Advances in the treatment of congenital cardiovascular lesions have led to a renewed interest in the treatment of acquired heart disease. Although this field could best be served by the perfection of the extracorporal heart, such devices are as yet not ready for human application. Meanwhile, various approaches through the ventricles and left atrium have been developed to treat valvular stenosis. Refinements in diagnostic tests and in methods of physiological investigation are of great aid in the proper evaluation of patients.

NOT long ago, Claude Beck, a pioneer in cardiac surgery, wrote: "Indeed, the time is not far off when operations upon the heart will be almost as common as operations upon the vermiform appendix."[3] This prediction has already been realized in some clinics. Furthermore, it is no longer an unusual circumstance to hear the heart discussed as an organ subject to surgical correction. This attitude has developed as a consequence of advances in the treatment of congenital cardiovascular malformations, which, in turn, stimulated a renewed interest in the development of techniques for the treatment of acquired heart disease.

The correct diagnosis and the proper evaluation of the abnormal function of the heart and great vessels at times is quite difficult. Physiologic investigations such as the measurement of the oxygen saturation of the blood in various parts of the vascular system, cardiac catheterization, angiocardiography, exercise tests, and electrocardiography are required. Above all, teamwork is essential in cardiovascular surgery, and the degree of success attained is dependent upon the combined skill and effort of all those involved in the diagnosis and treatment of these patients.

PATENT DUCTUS ARTERIOSUS

Since the first successful closure of a patent ductus arteriosus by Gross in 1938, the operation has had widespread acceptance. There is general agreement among cardiologists that a ductus which remains patent beyond the age of two or three should be closed, for the hazards of the ductus are greater than those of operative intervention.

The method of closing the ductus is not agreed upon by all cardiovascular surgeons. Thus Scott,[45] in reporting upon 180 patients operated upon at Johns Hopkins Hospital with five deaths and one recanalization, advocated the suture-ligature method of Blalock as being safer than division and suture. On the other hand, Gross,[26] Wangensteen,[52] and Potts[44] advocate division and suture. Jones,[36] in analyzing his experiences with 125 patients, gave a lucid description of the possible complication of the operation. There were four deaths in the series, and Jones concluded that there is not a "single, universally ideal technique" for the operative treatment of the ductus.

The author uses ligation more frequently than division. It is felt that if the ductus has been thoroughly mobilized so that it is possible to allow a space between the two or three braided silk ligatures there is little chance of recanalization.

CYANOTIC HEART DISEASE

The brilliant use of an artificial ductus arteriosus for the treatment of tetralogy of Fallot by Blalock and Taussig has been followed by numerous reports of its successful adoption by others.

In general, Blalock prefers not to operate before the age of two if the chances of survival to the age of two are 50 per cent or better.[8] He reported an over-all operative mortality rate of 17.7 per cent, but in those patients who survived a subclavian-to-pulmonary-artery anastomosis the mortality rate was 10.4 per cent. Potts[42] reported upon 181 patients. In most cases aortic-pulmonary artery anastomosis was carried out. The over-all mortality rate was 12.7 per cent, and in those who survived anastomosis it was 9.7 per cent. Paine and Varco,[40] and Holman,[32] advocate using the left subclavian artery in preference to the right subclavian artery.

Although experimental studies on venous shunts for complete transposition of the aorta and the pulmonary artery held some promise of success, the clinical application of these procedures, as reported by Blalock[10] and Hanlon,[29] was not very encouraging. Of the various operations, the best results followed the creation of the combination of an interatrial defect and an extracardiac arterial shunt.

It is not unlikely that certain anomalies of the pulmonary veins, particularly those in which most or all of the veins empty into the right atrium, may be improved by atriovenous shunts.[8, 12] Work in the surgical laboratory at Stanford University School of Medicine has demonstrated the feasibility of shunting large veins to the atrium, whereas small atriovenous shunts usually close by fibrosis.[21, 22] It is probable, therefore, that these procedures will be more successful in the older age groups, after growth of the veins has occurred.

Fell[19] and his associates have reemphasized the

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Presented before the Third General Meeting as part of the Panel Discussion on What's New in Medicine at the 79th Annual Meeting of the California Medical Association, San Diego, April 30-May 3, 1950.

practicability of the Potts procedure of direct aorta-pulmonary artery anastomosis in the small infant. They used it, with dramatic improvement, in three children with tricuspid atresia all weighing less than ten pounds.

COARCTATION OF THE AORTA

Following the first successful operations for coarctation of the aorta by Crafoord,[16] and Gross,[28] several series of cases have been reported. Gross recently described his experiences with 100 cases.[25] In nine, resection of the aorta was not attempted. There were 11 deaths. Of the 80 patients who survived the completed operation, 71 had total relief of hypertension, and eight had fairly satisfactory relief. The group at Johns Hopkins Hospital have reported upon 23 patients.[5] Thirteen were 21 years of age or above, while 10 were younger. Anastomosis was completed in 21 cases, with three deaths for the whole series. Physiological observations indicated that the hypertension in coarctation probably is not caused by a renal pressor mechanism. A number of interesting associated anomalies have been encountered during these procedures. Shumacher[46] successfully contended with an aneurysm distal to the coarctation. Unilateral hypertension due to involvement of the origin of the left subclavian artery in the area of aortic atresia has been recorded.[20] An associated patent ductus arteriosus is found occasionally. Long segments of atresia which preclude direct end-to-end anastomoses have necessitated the use of preserved homografts,[27] and the left subclavian has also been used to bridge the gap.[33]

CHRONIC CONSTRICTIVE PERICARDITIS

In a recent survey of 265 recorded operations for constrictive pericarditis, Holman[3] found that 21 deaths occurred on the operating table, 48 deaths occurred in the early postoperative period, 118 patients were considered cured, and 44 improved. Pericardiectomy was performed upon nine patients, four of whom had active tuberculous pericarditis. Pronounced improvement was noted in eight cases. One patient died. Holman stressed adequate exposure through a median sternotomy and liberation of all borders of the heart, including both cavae. Experimental work by Parsons and Holman, now being completed, indicates that most of the signs of constrictive pericarditis can be reproduced by interfering with the filling of the right heart through the constriction of the cavae, or the right atrium and ventricle.

Oglesby[39] and his associates reviewed the case histories of 53 patients observed at the Massachusetts General Hospital since 1914. Hydrothorax and calcification of the pericardium occurred in about 50 per cent of the cases. In all, 42 patients were subjected to pericardiectomy; 15 of them were essentially cured, and ten improved. Six patients died from the effects of the operation. From the standpoint of etiology, it is of interest to note that tuberculous involvement was proven in only nine cases.

MYOCARDIAL ISCHEMIA

In a series of publications Beck[2, 4] has reported a new approach to the relief of coronary artery disease. In operations upon dogs, the carotid artery was anastomosed to the coronary sinus in an effort to revascularize the cardiac muscle. The measurement of benefit of the operation was made by ligating the descending ramus of the left coronary artery at its origin. In another group of animals a free vein graft was used between the aorta and the coronary sinus. There were more survivors among the animals which had the protection of the shunt. One patient was operated upon, but a fresh infarct developed and death ensued. This procedure calls for considerable operative skill and leaves unanswered many fundamental physiological questions concerning the flow of blood in the heart muscle. Vineberg[51] explored the possibility of implanting the internal mammary artery into the ventricular wall and found that, under experimental conditions at least, communications with the circulation of the coronary vessels took place.[51]

Carter[13] and his associates have restudied Lezius' method of producing a coronary collateral circulation by means of cardiopneumonopexy. In a series of experimental animals asbestos powder was used to produce vascular adhesions between the lung and the heart, and the effect of coronary artery ligation was observed. The collateral stimulated by the adhesions reduced the mortality and the frequency of severe infarction resulting from coronary ligation. The operation was done on three patients with benefit in two; the other died due to infection. In another experiment, Carter and MacMillan[14] reported their experiences in developing a technique for the excision of portions of the ventricles, and stated that the possible use of such a procedure might include the resection of small aneurysms and foreign bodies, as well as areas of necrotic myocardium which result from acute ischemia.

CONSTRICTIVE VALVULAR DISEASE

In the past few years there has been a great revival of interest in the surgical treatment of constrictive valvular disease. The ultimate goal in cardiac operations for this purpose is the repair of the valves under direct vision, but this must await the development of an extracorporal device which will maintain the circulation while the heart is opened. A number of laboratories are engaged in the perfection of such an artificial heart: Gibbon[23, 24] of Philadelphia, who has labored for years on this problem, has predicted the perfection of his apparatus in the near future; Björk[6] of Sweden, Jongbloed[35] of Holland, and Karlson and Dennis[37] and their associates of Minneapolis have all attained a degree of success with various types of machines. At present this work has reach the point at which medium-sized dogs can be maintained for several hours while the heart is opened.

Meanwhile, valvulotomy is being applied clinically in the treatment of valvular stenosis by a number of surgeons. Smithy[47] and associates used both

ventricular and auricular approaches to the stenotic mitral valve and removed a small segment of anterior cusp by means of a punch type of valvulotome. In a series of seven patients, eight operations were performed with two deaths. In four patients there was clinical improvement, and in one there was little change. Harken[30] prefers the approach through the left auricle and believes that one should strive for a minimum amount of regurgitation and a maximum restoration of valvular function by incision or excision in the zones of the commissures. He and his associates reported operations upon eight patients. There were five valvuloplasties with three deaths, two interatrial septal defects, and one cardiac denervation. Some improvement was noted in those who survived the operations.

Bailey[1] and his associates in Philadelphia have meanwhile developed an ingenious method of performing a valvulotomy through the left auricular appendage in which the index finger is used as a guide to feel the stenotic valve and also to direct a valvulotome to the proper position. They, too, stress cutting the commissures rather than the valve leaflets, believing that valvular action is preserved and regurgitation prevented. They have now done a moderate number of such operations and have reported good clinical improvement and a comparatively low mortality rate.

The observation by Lutembacher that patients with mitral stenosis and an atrial septal defect develop less pulmonary edema led Sweet and Bland[49] to postulate that a vent between the pulmonary venous and systemic venous circulations might prevent the pulmonary edema which occurs under stress in these patients. They performed an anastomosis between the superior segment branch of the inferior pulmonary vein and the azygos vein in six patients and noted pronounced clinical improvement in three.

Several years ago, Rundle and the author attempted to test the physiological effects on pulmonary hypertension of an azygos vein to pulmonary vein shunt in the experimental animal. The investigation was not completed because of lack of a method producing a high degree of mitral stenosis which would result in lasting pulmonary hypertension. It was learned, however, that small vein-to-vein anastomoses frequently thrombose, a result which was no doubt encouraged by the lack of a pressure differential that would ensure a free flow of blood through the shunt.

Patients with pure pulmonic stenosis do not benefit from the creation of an artificial ductus arteriosus, but are improved by transventricular valvulotomy as described by Brock.[11] Blalock and Brock[9] recently reported their experiences with this method. In 19 cases there were two deaths, and considerable improvement was noted in the survivors.

In 19 experiments on dogs Templeton and Gibbon[50] reported the successful replacement of the tricuspid valve for an excised one in seven animals. The operations were performed through the open right atrium. The grafts were made from pericardium and vein, the pericardium proving to be the superior tissue.

The production and repair of interatrial septal defects has been studied in experiments on animals. Hanlon and Blalock developed a method of producing small atrial defects,[29] and have reported their clinical results with its use in the treatment of transposition of the great vessels.[10] The direct approach through the open right atrium, with the cavae occluded, is being used to make large septal defects.[48] Having made openings by this means in a group of animals, Swan and his associates devised a method of invaginating the auricular appendages into the defect, and reported satisfactory closures. They claim an advantage over Cohn's method.[15] Dodrill devised a double ring instrument which clamped the atria, approximating the lateral walls against the septum.[17] This permits excision of a portion of the septum in a bloodless field, through an incision in the outer atrial wall.

Murray[38] has described a method of closing septal defects, which he developed on 30 dogs. It consists essentially of passing sutures through the heart in the line of the interatrial septum and pulling them taut to close the defect. He has reported its use in a few patients, with moderate improvement.

VESSEL GRAFTS

For many years, surgeons have sought a satisfactory method for bridging gaps in blood vessels which have been damaged by disease or trauma. Pioneers in this field 50 years ago were Carrel and Guthrie. With the increase in interest in cardiovascular surgery, the need for grafts has again been emphasized. Gross[27] and his co-workers have demonstrated tissue viability of segments of aorta stored in special media for 35 to 40 days, and have reported excellent early results with the use of experimental and human homografts. Autogenous vein grafts to replace defects in medium-sized arteries continue to be used and appear to function satisfactorily.[34] Donovan[15] found that homogenous vein grafts thrombosed when anastomosed to the heart.

The author has been interested in this problem for a number of years, and, among other things, has found that arterial homografts will conduct blood satisfactorily for long periods of time. However, pronounced degenerative changes frequently occur in the vessel wall soon after transplantation, and ultimately the graft is replaced by fibrous tissue, with very little retention of normal aortic wall structure.[41] Fatty changes and calcium deposition were a frequent finding in the grafts.

These results call attention to the fact that the immunological and other factors concerned in maintaining viability of the transplanted tissue in the host must be understood before the ultimate goal in surgery—the replacement of a diseased organ with one that is healthy—can be achieved.

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What's New in Isotopes, 1950

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FOR many years the clinicians who came to me for radiologic consultation used to talk over the new advances in medical science and so keep me down to date. I always claimed that this was very nice—my friends did my reading for me. Now that I am permitted to channel my attention into the newly blossoming field of radiobiology, I am glad to undertake to do my friends' reading for them. Though the spirit is willing, yet the flesh is weak, and I find myself always behind in my reading. Moreover I am by nature intellectually excitable and readily led away on what smells like a hot trail of new development or new ideas, which may not be after all the game I am supposed to be pursuing.

I take my present assignment to be: Radioactive Isotopes in New Developments for Medicine. I shall therefore restrain myself in regard to bevatrons, linear accelerators, cosmic noise, pi and mu mesons, radioastronomy, roentgencinematography, cancer therapy by arterial injection of mustard, and the stone-in-the-anemone* method of treatment of infections and neoplastic diseases. But I might stop to mention the two new elements.

Uranium is the heaviest of the natural elements. Transuranic elements have been made by nuclear bombardment. Shall we call them "invented" rather than "discovered"? Neptunium and plutonium were made in developing the atomic bomb. By proper bombardment of these, americium and curium were made. Now two more, namely berkelium (55) and californium, have been reported. These have been made in only invisible amounts but are known by their chemical reactions. They are unstable, with half lives of 4.8 hr. and 45 min. respectively. This brings the number of known elements to 98. Prediction[64] has been ventured that elements No. 99 and 100 can exist (in their isotopes of mass 251 and 254, respectively).

The newest news in isotopes is of course the hydrogen bomb (fusion bomb), which is so new that it is not made yet[9] and maybe not possible. I will be glad to bend your ears on this subject for a couple of solid hours any time you will listen, but may not do it now. I can only express a present conviction that I do not momentarily apprehend destruction of all mankind by loosing upon the world radioactivity so enormous as to be lethal everywhere. I do think atomic warfare so bad that it ought to be given up and that statesmen ought to give first place to this problem, beside which all other problems are unimportant distractions. There is no adequate defense (except political) against even the present atom bomb, and only the most unsatisfactory therapy for radiation wounds. The Federal Government has begun general education about the A-bomb.[3]

TREATMENT OF TOTAL BODY IRRADIATION

The LD 50 of x-ray or gamma ray for man is not known precisely. It lies somewhere about 400 r. From experiments on mammals one learns: Strenuous exercise increases the lethality of total body irradiation.[35] Cysteine and other innocuous sulfhydryl compounds[44] may reduce mortality by half, if given before the irradiation; NaCN likewise.[28] Bone marrow proliferating actively (after hemorrhage, for example) is less injured by irradiation than when in a quiet state.[10] This goes against the radiologists' generalization that dividing cells are more radiosensitive. The spleen is able to pinch-hit for hematopoiesis[30] after destruction of bone marrow, and spleen and appendix are able to carry on for humoral immunity reactions[29] after destruction of the lymph nodes. Should we all take to wearing gamma-ray armor over the spleen? Blood transfusions are effective in reducing irradiation death rate. But one does not see how one is to get 20 transfusions apiece for hundreds of victims after an A-bomb blast.

CATARACTS

It has long been known that irradiation of the eye can produce cataract. The dose necessary may be as small as 600 r. Lately there has been report of a couple of cases of cataract developing in scientists working with a cyclotron.[1] The supposition is that these were induced by neutron rays. A number of cataracts have developed in the Japanese A-bomb victims.[14]

BETA RAY BURNS

At the most recent A-bomb tests (Eniwetok, 1948), several scientists foolishly handled material that had just been flown through the column of smoke from the bomb. The beta irradiation on their hands was extremely high. It is noteworthy that when sufficiently intense, beta radiation is palpable. The injuries were severe.[36]

INDUSTRIAL USES OF ATOMIC POWER

Power plants using uranium instead of coal for fuel are not yet here. We are warned that even if the energy were to be had for nothing, the power would still have to be distributed, and these distribution costs are several times the cost of present fuels.[23] Atomic (nuclear power) engines will never be small enough to run an automobile. It is open

* In Kingsley's "Water Babies," Tom, being still a bad little boy, drops stones into sea anemones to fool them into thinking a meal has come their way. Our present concept of sulfa drugs is that they imitate a related compound and take its place in cellular chemistry, but then prove misfits in the chain of essential vital reactions. Similarly the folic acid deviates for treating leukemia, and now more recently a purine deviate, guanazolo, for cancer (unhappily not successful).

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Presented before the Third General Meeting as part of the Panel Discussion on What's New in Medicine at the 79th Annual Meeting of the California Medical Association, San Diego, April 30-May 3, 1950.

knowledge that we are trying to develop nuclear energy for propulsion of aircraft (Fairchild Corp.) and of ships including submarines (General Electric Corp. and Westinghouse Corp.), but the projects themselves are secret, of course.[23]

MEDICAL AND BIOLOGICAL RESEARCH

Research in biological fields, applicable to medical problems, continues ever more actively along some of the older lines. One gets an idea by counting reports in *Nuclear Science Abstracts*. There are three or four reports per month on I^{131} for thyroid therapy, but the number of reports on its use for thyroid physiology recently has been more than double the previous six per month. Of 245 institutions getting radioactive isotopes from Oak Ridge for medical and biologic researches,[2] 167 are using I^{131}. As to P^{32} there has been no acceleration in the publication of reports—one per month on therapeutic uses, six per month on tracer uses.

P^{32} has this year been released for clinical use in treating polycythemia and leukemia. Presumably a physician may now look on it as applicable to the patient's interest. One still has to get it through an isotope committee in an institution.

It is still not demonstrated that P^{32} is superior on the whole to x-ray for management of leukemia. For polycythemia some would call it the treatment of choice. Lawrence[37] reports 172 cases, of which 121 were treated with P^{32}, with preservation of normal life expectancy.

More and more patients are being reported treated with I^{131} for Graves' disease and for thyroid cancer. One is hardly yet ready to abandon the old position, namely that the treatment of choice for hyperthyroidism is thyroidectomy.[34] One's estimate of what is best in given cases is undoubtedly going to be altered as experience perfects the clinical art of handling hyperthyroid patients with I^{131}.[60]

A number of cases of thyroid cancer with metastases are being reported held in check with I^{131} in large doses. The percentage of thyroid cancer cases amenable to such therapy remains small (about 10 per cent).[21] Some thyroid cancers that have taken up little or no I^{131} can be converted into iodine acceptors by (a) thyroidectomy[57] (probably a wise move early in the management of such a case), (b) thyrotropic hormone (30 mg. a day has been advised), (c) propylthiouracil (uptake bounces up to more than original level within a couple days of cessation of this drug),[62] (d) prolonged high-level water diuresis.[56]

NEW ATOMIC INSTRUMENTS

The instrument makers have been really busy and the apparatus available for the techniques of research with radioactive isotopes are ingenious and good. A new technique which is very promising is developed from an old one. I refer to scintillation counting, where one uses a fluorescent crystal and counts the flashes of light instead of measuring the total brightness of the glow. The first radium toy was the spinthariscope, in which alpha particles from a speck of radium produced tiny flashes of light in a zinc sulfide screen. This was the method used by Rutherford in his pioneering experiments on nuclear transmutations. Now this old technique has developed into the newest, and for some purposes promises to displace the Geiger counter. The physicists are doing new tricks with scintillation counters[33] because they are so much quicker than a Geiger counter (counting rates of a million per second), and because they are more efficient for gamma rays.

There are a number of refinements in the way of increased convenience: Machines that change samples automatically and print the measured activity of each, so that one can set one going in the evening and come back next morning to find two dozen specimens all measured; circuits to measure and record changing values of radioactivity over a period of time; circuits that calculate the counts per minute and show the value on a dial; machines to do chemical manipulations behind a lead barrier by remote control. These are nice to know about but are really pertinent only to the isotopic researcher, not to the practicing physician. The development of so-called nuclear emulsions, which have proved such a marvelous tool for the physicists in their researches on mesons, etc., in cosmic rays and from the big cyclotron, have increased the resolution of radioautographs until one can begin to see which cell in a tissue holds the radioactivity. Beta rays are least efficient at ionizing when of highest energy and produce lots of ions only after they have slowed down, which means when they are far from the source. Looking at the developed film, therefore, one cannot tell very precisely what was the point of origin. But some of the new emulsions will show tracks of beta rays even up to ¼ mev., which more than covers the energy of such biologically important tracers as carbon[11] and sulfur.

One new instrument worth mentioning is the strontium beta ray applicator for ophthalmic treatments. This is really not a new technique, for radium beta rays have been used for superficial therapy for half a century. An ophthalmic applicator using radium D has been on the market for years. The advantage of the new one is that radiostrontium (separated from fission products) is less costly, so that one may have an activity high enough to reduce the therapeutic applications to a fraction of a minute.

After waiting for more than a year, we see at last two manufacturers offering very narrow Geiger tubes designed to explore the living brain after administration of P^{32} to mark a tumor for the surgeon's guidance.[48]

Radiogallium has been shown to go rapidly to bone.[18] It is a beta emitter of fairly short half-life (14 hours). One fears to recommend any clinical trial of this for treatment of malignant tumors in the bones, because of the way radiostrontium actually produces malignant bone tumors. It seems unlikely that the difference in their half-lives will be very important if they be given in amounts to give comparable total dosage.

Radiocobalt (Co^{60}) is being made available in larger quantities and at much reduced price ($5 per curie after the first two curies). It can be produced in specific activity of several curies per gram in an old Oak Ridge pile. Newer pile design will undoubtedly make higher neutron fluxes available than the present 10^{12} n/cm^2 sec., with consequent raising of the specific activity attainable. This has induced a number of workers to draw plans for cobalt irradiators designed to use several hundred curies.[15] Such a source would be usable at much greater distance (between source and patient) than the radium "cannons" at present available. It would be more nearly comparable to a 2-million-volt x-ray tube. The lead shielding would be very heavy (half a ton or more), leading to severe engineering problems. Much weight could be saved by using a denser material than lead, such as gold or uranium. Gold is much too costly ($500 a pound, avoirdupois), and not to be rented from the Federal burial ground at Ft. Knox. Uranium has recently been released for open sale, but only 300 pounds of it, and the price quoted for the metal is $50 a pound. Dense alloys of tungsten are on the market at $10 a pound. A cobalt cannon has actually been built in England, but none as yet in this country.

Intracavitary treatment with a solution of Co^{60} inside a rubber bag has been suggested.[41] Substitution of Co^{60} for radium tubes and needles in present techniques is obviously promising.

That about ends all that is newly promising in therapy. One returns to the conviction that revolutions in medical practice may come from isotopes, but it will be through their use as research tools for making discoveries in the basic medical sciences.

TRACERS

Looking through *Nuclear Science Abstracts* one sees an increasing number of reports of tracer applications to biology—20 per month a year ago, 25 per month six months ago and 55 per month the first quarter of 1950. The variety reported is large and it is not to be expected that I can understand them all, nor that I can evaluate the importance of each and pick out for you what is most promising of the new discoveries and novel methods of attack. I shall talk about only a few, choosing those that seem scientifically curious or exciting. Another commentator might make quite different choices.

I^{131} is revealing many features of thyroid physiology: The thyroid takes up iodide, but not thyroxine.[13] In iodine starvation, I^{131} begins to enter the colloid within two minutes, but if a rat is given 22 mg. stable iodine per day the I^{131} stays in the follicle cells for an hour or more before entering the colloid. Hypophysectomy makes it stay in follicular epithelium.[38] In man, a slight increase in serum iodine increases I^{131} uptake in thyroid, but more than 5 or 10 mg. per 100 cc. inhibits it, the lower value being for clinical Graves' disease.[52] Sex hormones, male or female, depress I^{131} uptake (by pituitary depression).[42] Response of I^{131} uptake to thyrotropin can differentiate primary (thyrogenous) from secondary (pituitary) hypothyroidism.[46] Large doses of I^{131} (internal irradiation of thyroid) do not disturb thyroid function within the first ten days. But massive doses are followed by a triphasic reaction, first a release of iodide accompanied by lowering of protein-bound iodine, then a rise of protein-bound iodine (destructive action on follicles with release of colloid), and finally by myxedematous low level of serum iodine.[19] Thiocyanate is bound by thyroid more than by other tissues, but, curiously, propylthiouracil nullifies this.[63] Large doses of I^{131} in mice produce tumors (not neoplastic) of the pituitary (pituitary attempt at compensation?).[24] Epinephrine lowers I^{131} uptake in rats, but if the animals are adrenalectomized, then it increases uptake.[47] (Figure that out!) Measurement of rate of uptake by thyroid may be an improvement over per cent uptake attained, for clinical diagnosis.[43]

P^{32} continues to work hard for the biochemists interested in nucleoproteins. Synthesis of nucleic acids (ribose- and desoxyribose-) and their passage into mitochondria[32] and cytoplasm are readily followed in health, infections, regenerations and neoplasms. These experiments touch on the reproduction of chromosomes and the enzymatic activities that are the foundation of life itself. Nobody knows what revolutionary discoveries may be in the offing here. A phosphatase can transfer a phosphate group from one molecule to another and never let it become contaminated by phosphates in the surrounding solution.[5] Some enzymes have been shown to become contaminated by the substances they are working on.[31] Phosphorus turnover is 50 per cent higher in gastric carcinomas than in adjacent normal mucosa.[25] Will someone turn this to account for clinical diagnosis? By measuring mitotic activity of testicular epithelium, it has been shown that hypophyseal stimulation of testis is inhibited by the pineal.[54] Mosquitoes have been successfully labeled with P^{32} as an aid to control studies.[27]

Carbon 14 is a tracer whose usefulness is as wide as organic chemistry. One firm* offers 59 organic compounds labeled with radiocarbon (@ $100 to $500 a milligram). There is a little C^{14} in the atmosphere due to action of cosmic rays on nitrogen. Old stores of carbon show lesser activities, of course, because the C^{14} decays away (half gone in 5,000 years).[4] This has permitted measurement of the age of Egyptian mummies and confirmation of historical chronology. Some other C^{14} researches are interesting and perhaps important: Fat given by vein is readily metabolized.[22] Arterial wall is able to synthesize fatty acids from acetate.[12] (Has this any meaning for atheroma?) Normal persons break down one-half to three-quarters of dietary fat in the first 24 hours, but this is greatly lessened in hyperlipemic patients.[53] (This was determined with I^{131} as a tracer.) Only a little radiocarbon is retained in the body, but its location and concentration are

* Tracerlab: California office is at 2295 San Pablo Avenue, Berkeley 2, California.

uncertain; therefore it is still considered hazardous for human experimentation.[50]

Hemoglobin has been studied with C^{14} as well as Fe^{55} and Fe^{59}. Carboxyl-labeled glycine enters the globin, but not the porphyrin.[26] The globin remains chemically quite static. Iron turnover in plasma is astonishingly rapid. Iron utilization is high in iron depletion states and depressed in hemochromatosis, etc.[20] Some hemoglobin can be formed in circulating blood. Nucleated red cells (ducks) take up iron[49] and so do normoblasts and reticulocytes[59] (mammals), but normal adult mammalian red cells do not. Life of red cells in man is about 115 days.[6] In sickle-cell anemia, however, they do not live out their normal life, but are indiscriminately destroyed, some soon, some late.[39]

Penicillin has been successfully labeled with S^{35} and shown to enter the cytoplasm of susceptible staphylococci, not just bound to the cell wall.[17] What this means for ultimate understanding of the action of antibiotics I don't yet know.

Zinc is all through the body in very small amount. There seems to be some mechanism for its conservation and re-utilization. The concentration in human leukocytes is 25 times as high as in the erythrocytes.[58] In leukemia the amount per cell falls off but comes up again in a remission.

Gold is found to concentrate in arthritic joints and also in the wall of an abscess.[8] Silver also concentrates in abscesses.[61] Whether this can be used to diagnose deep-seated abscess we do not yet know.

Na^{24} has been used for some time to test the state of peripheral circulation, by giving a dose intravenously and measuring its appearance and persistence in a limb. More recently it has been given locally (into the muscle) and its rate of disappearance measured.[16] The diagnosis of cardiac disturbances by studying the curve of activity as a dose of Na^{24} moves through the heart has apparently made little further progress in the past year.[45]

Radiomercury has been used to study action of mercurial diuretics. There is an interesting first brief phase of low urine output with high concentration of mercury.[40]

Stable isotopes have been used in fewer researches. They are more difficult to measure. Moreover the radioactive ones are capable of revealing themselves in enormously greater dilution. Heavy hydrogen is of course the most readily and widely useful. Heavy water (D_2O) is the ultimate standard method of estimating total body water. It has been shown by comparison that the antipyrene method is clinically satisfactory.[51] Heavy nitrogen was used to label uric acid, and with this the body pool of uric acid was determined to be fifteen times as large in gout as in health.[7]

The foregoing listing holds some five dozen items that seemed to me novel, important or scientifically stimulating. Obviously there is not time for exploration of the implications of even a fraction of them. If some of you pick up one or two items that fit into the kaleidoscope of your cogitations and make a pattern, I shall feel this long recital has not been boredom unrelieved.

I have one more curious item. By irradiation with twenty million volt x-rays (200 r), living rats have been rendered perceptibly radioactive with a half-life of two minutes.

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The Background of Delinquency

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RECENT study refers juvenile delinquency to the following causes:

1. Overcrowding that forces children to spend time on the streets, flight from home circle, moving pictures, automobiles, radio, television.

Children, more than ever before, are in the company of adults where they are more exposed to adult discussions and conclusions, more often unwise than wise. This is disastrous because children with their limited experience are unable to deal wisely with what they hear and are taught to consider authoritative.

2. The multiplication of laws, to the point where they cease to command general assent and respect.

3. The growth, as a by-product of education, of scepticism and cynicism.

4. The decline of respect for the individual and for his rights.

5. Drift from religion—indifference, even antagonism to the Christian ethic on which our culture is founded.

6. No respect for the law, no fear of the police. "You can't touch me—I'm only a kid."

7. Decline of parental authority. Due to bad example, rather than lack of precept, admonition and reproof.

8. Cynical opportunism—railing against authority—evasion of disliked laws by adults, setting a conditioning of environment for children.

Such a list is limited to superficial surface symptoms; to the boils and carbuncles that indicate deep disorder in the social organism. What then is the virus that vitiates culture?

A recently issued study of juvenile delinquency in California concludes with this admirable declaration: "So we come back to the necessity of satisfying the emotional needs of every child; of providing every child with satisfactory human relationships. Only as we succeed in this, can we hope to build a good society." Those few sentences perfectly express the ambitions of all good parents, of all good pediatricians, and of every psychiatrist who has insight and integrity.

But, to accomplish these fundamental things, we would have had to be able to pick the grandparents and great-grandparents of our children, to have chosen their remote human ancestors, and have been able to influence their prehuman forebears as well. Those prehuman organisms whose conflicts and fears come down through the unending chain of chromosome-carried genes to every newborn infant, constituting much of the "Id" that Freudian dogmas theorize and assign to a place in the organism lying beyond the possibility of awareness, in the unconscious.

The fact that it is alive insures the organism instinctual urges to survive, and to survive in security and comfort if that be possible. But Nature is amazingly lavish and wasteful of life, and it is nothing to be surprised at that, finding some children ill-conditioned to the social order they are to occupy, unyielding Nature wastes their lives. Consider how many ova and sperm male and female organisms generate, and think how few reach their function as adult organisms, as parents. How wasteful, and yet how essential for the survival of those who are to survive. Think of the conflict between sperm and ovum as it begins in human mating. The sperm is an aggressive little bit of protoplasm, aggressive on the ovum; the ovum, in its turn, is resistant; sometimes it destroys the sperm; more often it capitulates. When it does, there is compromise; a compromise that produces the morula. This mulberry-like mass of cells, itself, exhibits the acme of aggression, attacking the lining of the womb as it strives for implantation there in a spot where security and survival will be favored. And the prenatal aggression essential if organisms are to live is only beginning! As the placenta comes into being and digs itself into the uterine walls, contact is made with the maternal blood vessels so that by further aggression the embryo can find protective security and food, not only for that day but for several hundred days to come. With birth, the billions of cells, expressing their biological need, urge the infant to aggression on the breast of the mother in order that they and it may find satisfaction.

From its origin, each cell of the new-born is endowed with aggressive ability to sustain conflict, and a gift for compromise when it encounters resistance. Aggression, conflict and compromise work together to insure survival, not only of the cells, but of the organism which the cells constitute. Nor is the survival of the organism all that is served. For these gifts assure that, when appropriate maturity arrives, there will be power to reproduce the organism and carry on the race.

In its emergent evolution throughout its life, the new organism, itself, will more than sum up the potentialities of the cells, and it will have to use its own aggressive powers to attack the resistant environment in order to acquire the food, air and water, the nitrogen and minerals that it must have if it is to function and to remain alive.

So the new-born child comes into the world as an organism equipped with aggression. It is an aggression ready to be aroused, aroused in response to hunger, a need that comes as a complex of conscious and unconscious desire. (Herein is a perfect demonstration of the unity of body and mind; the ultimate

contradiction of dualism.) The child's need is satisfied, a compromise is made with the mother because satisfaction has ensued for both. Each had a need: The mother to find relief from the pressure of milk in the breast, and the pressure of anxiety for the infant's welfare; the child to find the energy and building material his life and growth demand. At that stage, no one would think of calling the baby bad because it is aggressive and compelled to fight with such means as it has to gain satisfaction for its needs.

But the underlying forces that ultimately take children to the juvenile court, primarily, are just those qualities: Aggression, a sense of individuality, and a willingness to struggle for its own satisfactions.

In older children, the struggle to achieve its own satisfaction may be expressed as revenge, stealing, lying or destructive rowdyism. The latter fault becomes more intense and more disturbing during adolescence; and during adolescence, the sense of individuality, and will-to-power, in those badly-conditioned in early childhood, are often expressed as illicit sex adventures. The psychologists hold that all of these phenomena may be built up as defenses against dissatisfactions and unhappiness visited on children during their infancy. The sum total is anti-social behavior or "badness."

Can parents escape the responsibility for the disasters many of their children have to endure? Well, parents are what they are because they were conditioned to their behaviors and attained their beliefs in their own childhood. They are the products of a culture that had been imposed on them every day since they were born, and on their parents before them. Therein is the vicious circle: The misbehaving child; the family group in which the child was taught, trained and condition to be what it is; the culture which supplied the child's parents, teachers, spiritual pastors and masters with their sense of values and their value judgments.

A child in its family relations can find satisfaction and achieve maturity only if it feels secure, protected, free from uncertainty. And a family circle able to provide these essentials can exist only when the parents themselves feel secure, free from economic, social and personal uncertainty, and have faith in the rightness of their value judgments. In such a home, it makes little difference whether the moral atmosphere is one of austerity or of laxity, provided the children find, in that atmosphere, courtesy, certainty and consistency, leading to a sense of security and belonging; to feel secure, they must know that they are part of a group which is ruled by the ideal of "we" and not by the conflicting demands of many individual "I's."

The father and mother may be stern and exacting, provided they call out their children's respect and make them feel that they, the children, in turn, are respected and made a part of the family's utmost concern; that they belong to a group, not of "give-me's" and "go-getters," but one in which cooperation and mutual consideration are the dominant values. Within the range of their limited experience, children have an acute sense of justice and they estimate its administration much more accurately than many adults can give them credit for, or for that matter, than many adults do.

In these days, when the values men have lived by for twenty centuries are under question, the family circle feels the impact of doubt; the loss of faith; and the result is an uncertainty about right and wrong that not only is hard to live with, but which disrupts the sure pattern of family life. The pattern essential to the achievement for parents and children alike, of those qualities which make individuals mature, effective, useful citizens: Qualities that insure that they, all of them, at all ages, as George Preston points out, should be able to (1) live, (2) live with people, (3) live happily, (4) live productively, (5) live acceptably. In other words, that they will be healthy and stable and able to use the current culture with a minimum of conflict with their fellows and a maximum of satisfaction to themselves.

The organism is a bundle of potential reactions to objects and events in the surrounding world; for children, this is a constantly expanding world, especially in the matter of human beings. It expands from the simplicity of mother-child relationship in infancy, through preschool years to the complexities of school, preadolescent, adolescent and adult environments. Ability to deal with this increasing complexity is the test of maturity. E. B. Holt suggests that genius is a stage of development with high maturity, and that the ethical man has acquired an even higher degree of maturity, in that he is able to put an effective time lag between his responses and the stimulus that comes from the objects and events, many of them very remote, in time or space; and to do this with discrimination and the ability to choose the stimulus that best serves the organism's needs.

Not all parents are going to succeed in achieving this aim. The utility of nature's wastefulness appears in this. Did they all succeed, the world would have no prophets, no revolutionaries, no advance or, if you prefer it, no change, in man's cultural patterns; only dull conformity.

"Goodness" and "badness" have reached types and standards under various conditions of epoch, fashion and circumstance, that vary almost as much as day and night. Too often the standard of goodness for children has been measured by nothing more than how comfortable the little ones are to live with. Preserved Smith, in "The History of Modern Culture," writes, "At all times and in all countries, parents have lavished affection and care on *some* children. But in spite of this, cruelty, spite, ignorance, greed and other evil passions, as well as custom and a perverted sense of parental duty, have made the lives of many children, at most places and in most ages, unhappy."

"Ignorance, custom and a perverted sense of parental duty" function today more often than cruelty, spite, greed and evil passion; and even these latter are more frequently attributable to social and psy-

chic maladjustment of the parents than to inherited original sin. Most often these evils are due to distorted personalities acquired through deforming cultural influences that acted in the parents' childhood; and the parents' parents, in their turn, were subject to the same sort of crippling effects of overstrenuous cultural demands. Consider, for instance, what one great and good man, John Wesley, thought the duty of society to children: The children were "to be waked at 4:00 in the morning, to spend an hour in private devotions." To quote him, "As we have no play-days, neither do we allow any time for play on any day; for he that plays as a child will play as a man." In those days, silence, industry, obedience, respect to elders, truthfulness, respect for the property of others and for one's own pledged word, and conformity to the forms of worship, constituted the pattern of character that God-fearing parents strove to force their children into. The fear of the Lord was the beginning of wisdom but, unfortunately, it was held to be the beginning and end of the philosophy of child-rearing—fear not only of the Lord on high but also of the parents on earth. Fear, the breeder of anxiety.

Of course, our forefathers were striving to do right. To live happily, a child must know that he is only one of many; that the world does not belong to him alone. He must be obedient to circumstance, if not to tyrannical authority. He must learn to respect the property and rights of others, if he is not to be a thief, a liar, or one whose pledges are worthless. The ancients were right in their ambitions for their children's characters, but wrong in the way they went about trying for the result. They believed it possible, by moral and physical force, to fit a child into a preconceived character-pattern. They had unbounded faith in admonition, reproof and punishment, and their well-intended but mistaken efforts caused endless unhappiness, but no more than the lax or careless methods of many modern parents, perhaps not so much.

The child's possibilities for character development for good or for bad, are locked up in it at birth. To bring them out fully and finely, what it most needs physically, are sunshine, fresh air, and free range away from too close contact with too many grown-ups. What it most needs for character development is guidance in a simple environment that is allowed slowly to get more complex as the child grows older.

And also in every human breast there is lodged the tendency to react violently against injustice and tyranny, whether political or parental. On this trend of human nature is based all spiritual progress, all aspiration of the individual soul. Without it man could never have ascended from the slaveries of primitive authoritarianism or of feudal medievalism.

Such an instinct is awake and is active in the breast of every child, but the child's lack of experience, and the parent's lack of comprehension or of consideration, often bring about a degeneration of this noble spirit until it becomes the blind, devastating force that the psychologists have called "negativism"—negativism, the destructive spirit which brings the child into unremitting conflict with his parents, and the adult into battle against the reasonable things of life.

One may well ask how far this widely cultivated negativism provides the germ for the disrupting philosophy of positivistic nihilism that is overtaking the world, filling the minds of men with doubt, uncertainty and distress.

Man's access to the universe is exceedingly limited. It is limited by his five senses, which keep him informed of some of the changes that occur in his immediate environment, and of these changes only. Through this narrow access our forefathers gained a picture of a universe of stars and stardust, of fire and water, earth and air. Within the last century, there has been added a concept of matter, made up of atoms and molecules, both beyond vision and apprehensible only by virtue of imagination. From such a concept of matter grew science and the materialistic philosophy that has come to be ascendant in the 19th and 20th centuries. Today the accepted picture is of a dynamic universe of scattered galaxies of stars at immense distances apart, spread infinitely through what man's mind conceives to be space. Each galaxy is made up of stars, each star itself a sort of lesser galaxy of incessantly moving molecules and atoms, each atom in its turn reproducing the timeless whirl of its constituent particles. A retelling of Heroclitus' dream that "all things flow"—yet who can say with certainty that these figments of the human imagination picture anything of cosmic reality. At the best, what is pictured is an unfeeling universe, terrible and impersonal.

It has been said, "No man can stand naked before the stars." Because of his instinctive fear of the terrible, unfeeling, impersonal universe, in his deepest nature, early man was compelled to search for comfort; for something which would allay his fears. Thus he was impelled to find a satisfying explanation of himself, of his environment and of their interrelation. If he were to survive, he had perforce to find some meaning, some reason for the universe and for himself as part of the universe.

And to help him out in that search for comfort, that flight from fear of the unknown, man called upon a quality which seems to be as intimately a part of him as the material of his blood and bone—the power of phantasy, of day-dreaming. Historically, the earliest known to us of this flow of phantasy was expressed in what the anthropologists call animism, or, better, animatism, in which all the forces of nature which he could discern were endowed each with a life of its own. It is a phantasy that still dominates the thinking and feeling of primitive tribes and, through that human quality, which Professor Freud has personified as the Id, it reaches into our own daily lives, into even that of the most sophisticated modern man, bringing with it residues of fears and perplexities inherited from human and prehuman ancestors.

However, as a major force in man's attempt to adjust himself comfortably to the universe, in time

animatism gave way because of the accumulation of what we are pleased to think of as factual experience. It gave way to anthropomorphism—another form of phantasy which personifies nature and endows her with all the qualities a man believes himself to have. By analogy with his own behavior, earlier man explained the otherwise incomprehensible behavior of the world around him. In the process of this anthropomorphic adjustment, various tribes, races and breeds of men, according to their experience and the ease or difficulty they encountered in finding the means of survival (food, water, shelter), created for themselves many gods in their own images. In the further flow of time, as men came more and more to be integrated into social groupings, and to reach more or less common ideals, monotheism, based upon the experience of the father of the human family—protector, director and dictator—was widely accepted.

For us of the Western world, the priestly servants of such a sovereign God formulated statements of purpose and principles which seemed best to serve the survival of the human race under the circumstances of the time. Thus, humanity was supplied with principles woven into a pattern which seemed to make it easier for the general body of men to fulfill these purposes. For twenty centuries, those principles and purposes have been accepted by what we know as Western civilization. They have been expressed in the various philosophies and religions, designed to serve the survival, security and satisfaction of human beings in this unfathomable space which man has given the name Universe. Out of these developments arose the ideas of evil and good, of taboo and permissibility; and with them came the establishment of authoritative social orders varying with era, locality, climate, sacerdotal ambition and economic need. The leaders of such social orders became the dispensers of the authority necessary to keep civilization functioning in ways they approved.

The family was recognized as a biologic expression of such an order, not only as a biological unit, protective of its individuals, but as a social organism, the nucleus of a larger society. The displacement of the family interest as an ultimate by the individual's interest is one of the crippling defects of modern society. Man, as he struggled for personal security, comfort and survival, acquired concepts of good and evil. All that he fancied served these ends he accepted as good; what he felt hindered them, evil.

The stage of man's history when he pictured nature and nature's forces as endowed with human qualities was the era of priests, kings, religions and philosophies. The primacy of that era was at its height five hundred years ago; it remained dominant until the mid-nineteenth century and today still is extraordinarily influential, perhaps even more so than the materialistic, mechanical teachings that are supposed, with the coming of science, to have overthrown it.

It is odd to think that all the mathematics and physics that give validity to the concepts of Galileo and Newton are based fundamentally on a phantasy, on the concept of an imagined point and a belief in lines of force passing through points postulated to occupy the exact centers of bodies; abstractions that can be useful only in terms of the concepts of number and mathematics. Points and lines are purely imaginary quantities. They cannot be created physically or as such be appreciated by our senses and they are translatable to them only as parts of visible measurable surfaces. No one knows whether numbers were invented or were discovered, whether they are part of a natural order or merely ingenious devices man has created and uses in his attempts to explore his environment.

All this may seem to have no bearing on the problem of child behavior, but it has, for mankind's convictions about good and evil dictate the family judgment of the goodness or badness of its children. On this conviction is based the one essential quality of family life which provides the important conditioning forces out of which will emerge the child's "style of life." One thing above others that a child needs to be protected against is confusion in authority, and another, equally important, is uncertainty in family purpose. And yet, how can it be so protected when the social order itself is so uncertain and so disordered? Nowhere today is there any possibility of certain knowledge or of a consistent development of an agreed canon of desirable behavior. We suffer from some of the residues of animistic conceptual method. Half our actions, social and intellectual, are dictated by residues of anthropomorphic belief; residues that, in the light of current materialism, some of us resist with more or less determination. The result is that we are an uncertain generation of little faith—disillusioned, even while we seek shelter and comfort in new phantasies.

C. E. M. Joad recently put the present issue of our confusion this way. He was dealing with the latest expression of the materialistic, mathematical philosophy, a revival of Comte's positivism, a restatement of that philosophy, buttressed by an appeal to up-to-date physical science. Joad says, "The traditional philosophy of Western Europe holds that transcending the familiar world of things known to us by our senses and explorable by science, there is another of reality that contains values which are qualitative. Of these values, goodness, beauty and truth are preeminent and are the sources, respectively, of ethics, aesthetics and logic. In other words, it is because the universe is, or contains, a moral order that some things are right and some wrong; because it contains an aesthetic order, some things are beautiful and some ugly, and because there is such a thing as truth, that certain judgments are false and others true. Many philosophers would add that the universe contains also a Deity, the source of the values Goodness, Truth and Beauty, these being, as religion puts it, the modes of the Deity's revelation to man. Metaphysics, for these philosophers, is the study of the reality that

transcends and underlies the familiar world of sense impressions and is, therefore, in part the study of values and of God.

"These ideas are the general outcome of Western philosophical thinking, reinforced by Christianity over the past nineteen centuries. It is a dual purpose of Western philosophy to reveal truth and to increase virtue by providing man with principles to live by and purposes to live for—principles derived from an examination of values. The principles are those of morality and the purposes are the attainment of an increase in what is good, beautiful and true, in one's individual life and in the total human community."

With the increasing influence of a materialistic philosophy of science on opinion, doubt, which is essential to the purpose of science, began to gather quite illogically about the conception of transcendental values; so that, with the advent of the 19th Century, positivism gathered vitality and emerged as "Logical Positivism." As a result this large and very influential school among leaders of scholarly opinion tells us that there are no such things as value judgments, for, say these men, "there are no values, and the true function of philosophy is no more than to clarify the propositions of science by exhibiting their logical relationships and by defining the symbols that occur in those propositions."

These logical positivists tell us that propositions which have meaning fall into one of two classes; those that concern empirical matters of fact and those which philosophers have called "a priori," and which concern the "relations of ideas." The former have meaning only if they can be verified—verification meaning that some possible sense experience should be relevant to determine their truth or falsehood. The latter group, those which concern the relations of ideas, are the propositions of mathematics and of logic. They are certain, say the positivists, only because they are purely analytical.

These thinkers maintain that all metaphysical assertions, that is to say, all assertions about a realm of values transcending the world accessible to sense are meaningless because only those empirical propositions have meaning which can theoretically be verified; and since any sense experience must inevitably be an experience of the familiar world and not, therefore, of an order of reality transcending the familiar world, no metaphysical proposition can be verified and it cannot be asserted that there is a non-empirical world of values.

Therefore, according to the teaching of the positivists (and they teach widely) all value judgments are valueless; hence, ethics, aesthetics and religion are without worth. They say that the statement, "This is wrong," cannot be wholly reduced to empirical concepts since there is no sense experience of the quality of wrongness. Therefore, as it is not empirically verifiable, it follows that the statement, "This is wrong," is meaningless. Likewise, the statements, "This is beautiful," "This is good," "This is bad," because these express value judgments and cannot be analyzed, they would dismiss as meaningless. Any such statement, they say, can do no more than express the moral, aesthetic or religious feelings of the person who uses them. It cannot be argued about. Extending this line of discussion, the positivist philosophy dismisses as without meaning the ideas, not only of Deity, but even of belief and disbelief, for, in their view, God is a metaphysical term belonging to an assumed reality that transcends the world of sense experience. The idea of God, therefore, comes under the general ban on all metaphysical statements; to say that He exists is neither true nor false; it is neither atheistic nor agnostic; it is simply meaningless. It is the contention of this philosophy that both scepticism and doubt become equally irrational; belief and disbelief cease to be in the list of subjects suitable for intellectual consideration, and philosophy is left without any wisdom to offer the world or any guidance for the perplexed human race.

It may seem that it is overweighting the teaching of a small group of philosophers to attribute to it widespread social influence, but such ideas diffuse downwards; rapidly, inevitably reaching innumerable individuals to whom philosophy is an alien word. However, amongst these are myriads of the uncertain, confused, fearful, dissatisfied and resentful. These avidly absorb this materialistic nihilistic teaching with all the greater ease when assured, as so often they are, that this gospel of denial is based on "Science," a word, a verbal symbol, that for those ignorant of the activities and practices of physical science, has taken on implications of magic.

What has this to do with good and bad children? Everything! Increasing delinquency may well be the forerunner of social collapse. The confusion and uncertainty about what is bad and what is good that these philosophical conflicts promote, invade countless families and are reflected in unsound intrafamily relationships, robbing children of the certainties and serenities essential if they are to become well adjusted to the family situation. Dwelling in such unhappy, uncertain, confusing family conditions, the little ones are robbed of the education, conditioning, training and the practice in behavior necessary if they are to live their own future lives happily and efficiently. And, in addition, the situation tends to exalt and exaggerate the feeling of egoistic individuality at the expense of group unity. Such a philosophy felt but not realized is a source, probably, of the adult unrest which so often drives grown-ups of the family to retreat into alcoholism, thus importing further irrationality, uncertainty and discomfort into the family life. It is often overlooked that the parents' habitual moderate alcoholic indulgence is as apt to create these uncertainties and these family life disorders as a parent's occasional indulgence in excessive drinking.

All these intrafamily disturbances conspire to rob the children of the education, behavior and conditioning for entering into personal relationships necessary if they are to live their own future lives

happily and efficiently, able to meet any social situation of which they may find themselves a part. The healthy growth of the individual depends on a healthy family life. And that, in itself, depends on a satisfying understanding and utilization of moral values.

Thus, so-called "bad" children are fruits as well as the victims of defective value judgments on the part of families—defective judgments derived from a culture that exalts materialistic hedonism, and rejects transcendental values; a culture that discourages the enjoyment of life for its own sake; that leads men to forget the lesson that gave the Greeks contentment; the lesson that Euripides expressed in the lines, "He who knows as the long day goes that to live is happy, has won his heaven"; a culture that robs man of comfort in those dreams of his that give him confidence in the idea of transcendental values; values which his consciousness has no difficulty in utilizing as the bases of truth, beauty and justice; ideas which alone have enabled humanity to rise above the beast level; ideas without which the most materialistic scientific investigator would have no criterion of honesty, a virtue which, after all, is what gives science its ultimate worth, and the scientist his power and his satisfactions.

And, so far as children's social delinquency is concerned, the so-called "bad" children are the fruits of defective judgments on the part of families responsible for bringing up the young. Value judgments distorted by materialistic cultures which supply families with the only basic materials they can have for their moral standards in a world that has rejected the transcendental.

We have to ask ourselves, then, whose is the responsibility for the delinquency of the child?—the child's, its parents' or the social order's which, through its encouragement and taboos, establishes bases for such values as the parents must acquire.

I wish that every parent might read, and learn by heart, the exquisite lines of Charles Peguy:

"Childhood, a budding, a promise, a pledge. . . ."

". . . . that little earnest of a bud which shows itself at the beginning of April.

"It is the bud that looks as if it were the tree's parasite, as if it ate at the tree's table . . .

"And yet it is from that bud, on the contrary, that everything comes.

"Without a bud that once appeared, the tree would not exist. Without those thousands of buds that come out once at the beginning of April and sometimes in the last days of March, nothing would last, the tree would not last and would not keep its place as a tree. . . .

". . . All life comes from tenderness. All life comes from that tender, delicate April bud. . . .

"Now I tell you, says God, that without that late April budding, without those thousands of buds, without that one little budding of hope, which obviously anyone can break off, without that tender, cotton-like bud, which the first man who comes along can snap off with his nail, the whole of my creation would be nothing but dead wood.

"And the dead wood will be cast into the fire."

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Leading Causes of Childhood Death

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SUMMARY

The over-all rates of death in childhood decreased five to ten fold during the first half of the century, with the greatest drop occurring in deaths due to infections. The death rate due to accidents has shown a relatively slight decrease; hence, accidents are now the leading cause of childhood death, and in California account for 32 per cent of the deaths in the group 1 to 15 years of age.

In California, and among certain insured groups of children, cancer is the leading or second leading cause of death due to disease. There is indication that the incidence of leukemia is increasing in early childhood and in the older age groups.

Accidents, the leading cause of childhood death, do not happen; they are caused, and so can be prevented. The medical profession should concern itself much more actively in the field of accident prevention.

A PROFESSION whose main concern is with the postponement of death and cure or prevention of disability may well scrutinize the major causes of these disasters. Dickinson and Welker[4] have proposed two new measures of death, namely the number of life years, and the number of working years lost. The former is based on the life expectancy of the individual at the time of his death, and the working years are calculated on the premise that the normal individual would work from age 20 to age 65. When these new measures are applied to the causes of death for all ages, accidents become the leading cause of working years lost and the second leading cause of life years lost. Thus the death of children and young adults is doubly disastrous, because of the economic loss to society of their working years and the large number of life years lost to the individual and his family. The causes of early death are obviously of greater importance than are the causes of death of older persons. Everyone must die of something some time, but still remote is the medical millennium when death will only be due to senility, and will only occur at some very elderly optimum age.

It is of considerable interest to examine the changing leading causes of childhood death over the first half of this century. Tables 1, 2 and 3,[3, 5, 7] show the five leading causes of death by age groups for selected years. The death rates from all causes in each group have declined sharply. The greatest decrease has occurred in death caused by the infections. For the communicable diseases of childhood, diarrhea and enteritis, tuberculosis, and influenza

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Presented before the Section on Pediatrics at the 79th Annual Session of the California Medical Association, April 30-May 3, 1950, San Diego.

TABLE 1.—*Death Rates for the Five Leading Causes of Deaths by Age Groups for Selected Years—United States*
(Rate for 100,000 Estimated Population)

	Under 1 year
1916	
All causes	10,100.0
Diarrhea	2,410.0
Premature births	1,930.0
Pneumonia (including influenza)	1,430.0
Congenital malformation	680.0
Injury at birth	420.0
1947	
All causes	3,373.1
Premature births	1,162.0
Congenital malformation	483.3
Pneumonia	373.6
Injury at birth	370.1
Asphyxia	162.9

TABLE 2.—*Death Rates for the Five Leading Causes of Deaths by Age Groups for Selected Years—United States*
(Rate for 100,000 Estimated Population)

	Age 1-4 Years		
Causes	1900	1920	1947
All causes	1,983.8	987.2	159.1
Pneumonia	386.6	283.7	24.8
Diarrhea	303.0	141.3	.....
Diphtheria	271.0	90.5	.....
Tuberculosis	101.6	.....	6.6
Measles	87.6	.....	.....
Accidents, non-motor	.....	73.5	30.1
Whooping cough	.....	57.0	.....
Congenital malformations	.....	.....	12.5
Motor vehicle accidents	.....	.....	12.0

TABLE 3.—*Death Rates for the Five Leading Causes of Deaths by Age Groups for Selected Years—United States*
(Rate for 100,000 Estimated Population)

	Age 5-14 Years		
Causes	1900	1920	1947
All causes	385.9	263.9	69.1
Diphtheria	69.7	28.0	.....
All accidents	38.3	.....	.....
Pneumonia	38.2	45.1	4.4
Tuberculosis	36.2	22.4	.....
Diseases of heart	23.3	17.4	3.9
Accidents, non-motor	.....	31.9	16.7
Motor vehicle accidents	.....	.....	10.0
Cancer	.....	.....	3.2

the decrease has approximated 50 to 90 per cent since 1930.

In this same interval the decrease in the accidental death rate has been only 19 per cent. Such diseases as diarrhea, diphtheria, and measles, which were among the five leading causes of death during most of the first quarter of the century, are now far down the list in an insignificant place. With the decline of disease as a cause of death, accidents have assumed a place of leading importance. In the United States accidents account for 26 per cent of the deaths in the 1 to 4 year age group, and for 38 per cent in the 5 to 14 year age group. In California the percentage of children lost by accidents is slightly higher; 28 per cent in the 1 to 4 year age group and 40 per cent in the 5 to 14 year age group. Of the deaths in the 15 to 24 year age group, 46 per cent are accidental.

At present the important causes of death due to disease in the United States in the 1 to 14 year group are pneumonia, congenital malformations, tuberculosis, diseases of the heart, and cancer. These all rank far below death by accident in numerical importance.

The leading causes of childhood deaths in California are at variance with corresponding data as regards children in the United States as a whole. In Tables 4, 5, and 6 [10, 5] are presented the leading causes of death by age groups, expressed in per cent of total deaths for each age group. (The vital statistics for California are available only in this form.) The data are nearly identical for children under one year of age, except that pneumonia rates third in the United States, and fifth in California. However, in the 1 to 4 age group in California cancer is the second leading cause of death due to disease, and the leading cause of death due to disease in the 5 to 14 year group. This same high rank of cancer exists in the same age groups among the children insured in the Industrial Department of the Metropolitan Life Insurance Company.[8, 9] It is probable that this high rank of cancer as a cause of childhood death in California and in the insured group of children indicates that superior medical care and living conditions have resulted in a lowering of the death rate from infections. There is, however, some evidence that the incidence of cancer, especially leukemia, is increasing. In any case it is being diagnosed more frequently.

TABLE 4.—*The Five Leading Causes of Childhood Deaths by Ages in 1947*

(Expressed in Per Cent of Total Deaths in Each Age Group)

Under 1 year	
In California:	
Premature births	35.4%
Congenital malformations	14.3%
Injury at birth	13.2%
Prenatal and natal	9.6%
Pneumonia	9.6%
In the United States:	
Premature births	30.4%
Congenital malformations	14.3%
Pneumonia	11.0%
Injury at birth	11.2%
Asphyxia	4.8%

TABLE 5.—*The Five Leading Causes of Childhood Deaths by Ages in 1947*

(Expressed in Per Cent of Total Deaths in Each Age Group)

Age 1-4 years	
In California:	
Accidents (excluding motor vehicle)	17.1%
Pneumonia	11.9%
Motor vehicle accidents	10.9%
Cancer	8.6%
Congenital malformations	8.5%
In the United States:	
Accidents (excluding motor vehicle)	18.8%
Pneumonia	15.2%
Congenital malformations	7.8%
Motor vehicle accidents	7.5%
Tuberculosis	4.2%

TABLE 6.—*The Five Leading Causes of Childhood Deaths by Ages in 1947*

(Expressed in Per Cent of Total Deaths in Each Age Group)

Ages 5-14 years	
In California:	
Accidents (excluding motor vehicles)	22.0%
Motor vehicle accidents	18.0%
Cancer	12.1%
Pneumonia	4.8%
Tuberculosis	4.4%
In the United States:	
Accidents (excluding motor vehicles)	24.1%
Motor vehicle accidents	14.4%
Pneumonia	6.3%
Diseases of heart	5.6%
Cancer	4.6%

Examination of the death rates due to leukemia (including the aleukemias) for the United States by age groups from 1930 to 1948, and for England and Wales for 1931 to 1945, reveals that there was a steady rise in the death rate due to leukemia for all age groups. The rate of increase was relatively high in the very young (deaths from this cause doubled) and even greater in the very old where the increase was fivefold. The rise was slight in the middle age groups (see Charts 1[6] and 2[1]). Had the increase been due solely to improved diagnosis, it would have been uniform for all ages. It is beyond the scope of this paper to speculate on the possible causes of the increasing incidence of leukemia.

The annual child accident toll for the United States is shown in Table 7.[2] The death rate from diphtheria (for all ages) has been reduced from 40.3 per 100,000 population in 1900 to 0.6 per 100,000 population in 1947. In this same interval the death rate from all accidents has fallen only from 72.3 in 1900 to 69.4 in 1947. It is now easy to prevent diphtheria or to cure it, and obviously it is a medical responsibility to do this. Ought it not be as obvious that prevention of the death of a child by drowning or poisoning, or falling out of an automobile, is also a medical responsibility?

Physicians and the laity both have an attitude toward accidental death and disability quite differ-

ent from the attitude toward diseases causing mortality and morbidity. This is perhaps because medicine—inoculations, laboratory research, test tubes, microscopes, and animal experimentation — plays little part in accident prevention. There is no doubt that a child killed or disabled by an accident is just as dead or disabled as thought poliomyelitis, cancer or rheumatic fever had been the etiologic factor. A great deal of publicity is given the diseases mentioned; drives are made to raise funds to carry on research and give care to the victims. And it is desirable that this be so. Yet parents tend to worry excessively about their children's developing certain diseases, especially poliomyelitis or rheumatic fever, while they are concerned hardly at all over the possibility of death or disability by accident, even though the latter is many times more liable to happen than the former. The annual accidental death of 14,000 children far exceeds the deaths from many of the leading disease killers combined. Considering the importance of accidents as a killer and disabler of children, relatively little activity is directed by any group toward prevention of them; and the medical profession gives prevention hardly any attention at all.

Most accidents are preventable, but prevention is a complex and many-faceted problem and will require the efforts of many groups besides the medical profession. Yet just as it is the duty of physicians to routinely inoculate children against whooping cough, diphtheria and tetanus, and where indicated, against other diseases, and to prescribe vitamins to prevent the deficiency diseases, so also it is their duty to instruct parents how to prevent accidents, and to help spread the knowledge that most accidents are preventable.

Young mothers must be instructed never to leave a baby on a surface from which it may roll—witness the number of babies who fall to the floor the first time they turn over. They must be cautioned always to close safety pins; they must be told how to make a bed with a firm flat surface in which the baby

TABLE 7.—*United States Child Accident Toll*

Under 15 years		
Yearly Death Total		14,000
Motor vehicle accidents	3,500	
Burns, scalds and explosions	2,700	
Drownings	2,300	
Mechanical suffocation	1,400	
Falls	900	
Firearms	600	
Poisons	600	
Railroad accidents	300	
Injuries, over		1,500,000

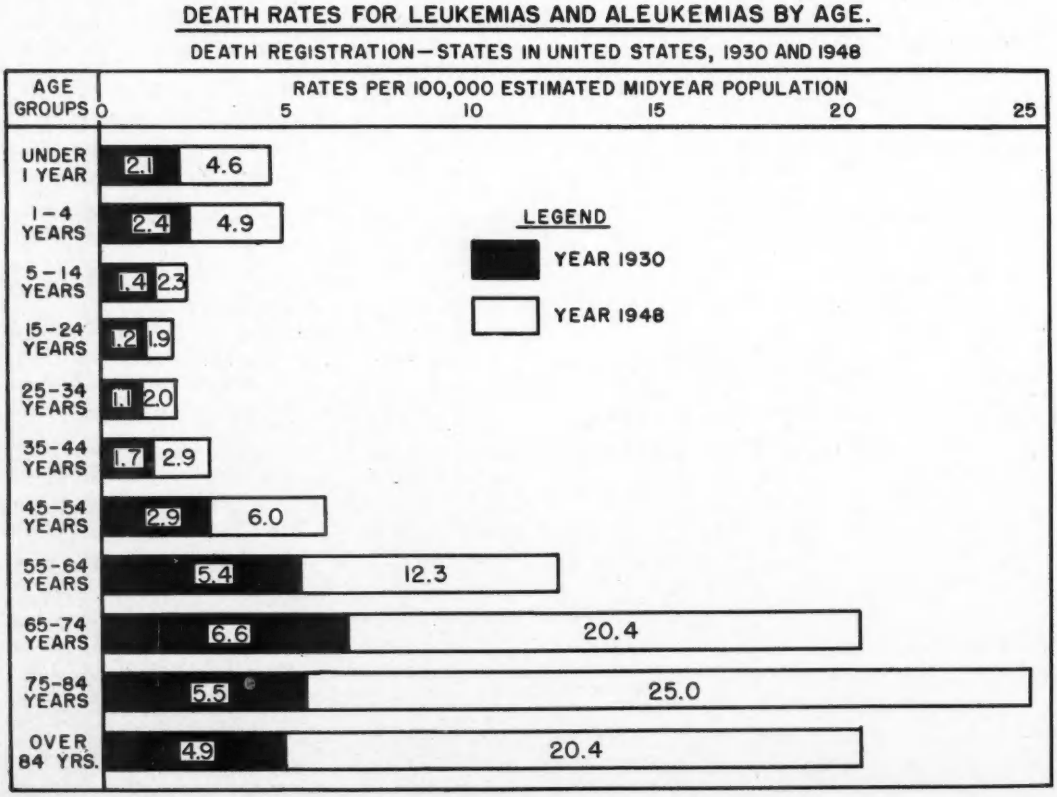

Chart 1

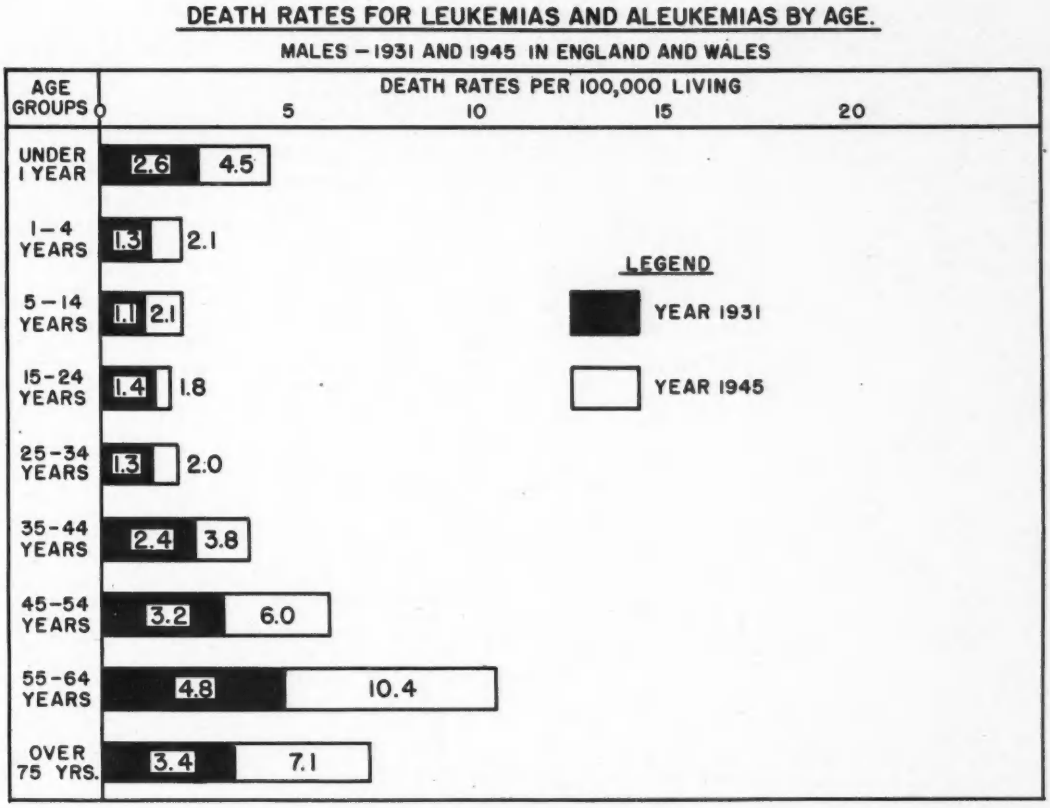

Chart 2

cannot suffocate. As the child gets older new dangers must be warned against, and his environment rendered safe. Heaters must be guarded to avoid burns and setting fire to clothing; care must be taken to prevent toddlers' pulling of vessels of scalding fluid onto themselves; and accessibility to matches must be prevented. Six hundred children a year, most of them under five years of age, die from poisoning; from eating sleeping tablets, aspirin, caustics, antiseptics, cleaning fluids, arsenic, insecticides. Such deaths can be prevented by invariably keeping all these dangerous substances inaccessible to children.

Falls account for the death of nearly a thousand children yearly. Hence parents must be cautioned to so supervise and control their children that falls from windows, roofs, trees and other heights may be minimized. Improved supervision and exercise of proper caution is also necessary to prevent drowning. Each year some 2,300 children, most of them over five years of age, drown. Most of the drownings follow falls into water from docks, river banks, or into garden pools, watering troughs, wells, or swimming pools.

Prevention of deaths in accidents involving motor vehicles, which annually take the lives of 3,500 children, is mainly a problem of traffic safety. However, many injuries and some deaths could be prevented by use of seat belts to prevent small children being thrown against the dashboard or out of the car in the event of collision or sudden stopping. The all-too-frequent fall of a child from a moving car can be prevented by the constant use of a special safety device which prevents the opening of car doors from the inside until the device is released. Small children must be kept out of streets and must not be allowed to play in driveways where so many have been run over by a backing car.

Some children, as some adults, are accident-prone. It is possible that some parents foster accident-proneness in their children. When the same child has been involved in repeated accidents or stomach washings, psychiatric counseling may be in order.

By constantly instructing mothers in child accident prevention methods, and by stimulating community propaganda on accident prevention, physicians should play the leading role in the reduction of the accidental death rate, just as they have played the leading role in the reduction of the death rate due to disease.

The medical profession might properly form a Research Foundation for the Study and Prevention

of Accidents. Since accidents do not *happen* but are *caused*, this leading cause of childhood death can be prevented.

Discussion by HARRY F. DIETRICH, M.D., *Beverly Hills*

Dr. Clark has documented one of the most important problems in pediatrics, and whether we like it or not, we must assume responsibility for its solution. From the standpoint of importance, the first four problems of pediatrics are the prevention of prematurity, the prevention of congenital anomalies, the prevention of accidental death and crippling and the prevention of emotional maladjustments. If we wish we can probably pass the responsibility for the first two problems to the obstetricians, but we must actively contribute to solution of the problems of accidents and emotional aberrations.

I can agree with everything that Dr. Clark has said, except her intimation that smothering is an important cause of death. Although a large drunken mother might conceivably smother a small infant sleeping in the same bed with her, I have never known of a well baby smothering. Infants, however, have been actually stranged by contraptions used to prevent theoretical smothering. I believe that the 1,400 deaths from smothering indicated on Dr. Clark's chart represent the same coroners' mistakes that keep the thymic myth alive—insufficient or inadequate autopsies. Bowden in Australia recently studied 40 cases of alleged smothering, and in every instance found some other valid cause for death. He suggested that what we in the United States need is not the proposed "Foundation for the Prevention of Smothering" but a "Society for the Performance of More and Better Autopsies."

The individual pediatrician can help in the solution of the accident problem at three levels:

1. In the physician-patient relationship he can advise parents on accident prevention.

2. At the community level he can mobilize existing groups and direct them to this laudable goal. In Los Angeles, Miss Rhea Ackerman of the Children's Hospital has been singularly effective in energizing awareness to the accident problem. She has recruited hospital auxiliary groups, stimulated parent-teacher organizations, delicately needled the National Safety Council, cajoled the newspapers and radio, interested the Boy and Girl Scouts and in general acted as the catalyst for effective community action.

3. The need for national action is two-fold. The value of country-wide dissemination of accident prevention information is obvious. Less apparent is the glowing need for statistical information on serious injury and permanent crippling from accidents. The pediatrician, indeed, has much to do.

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Chronic Ulcerative Colitis—Psychosomatic Factors

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SUMMARY

In six cases of idiopathic ulcerative colitis here reported, close correlation with emotional stress was shown. Psychosomatic relationship seemed definite. Experience with 85 patients with ulcerative colitis has led to the suggestion that emotional stress may be causative or a predisposing factor in some, perhaps all, such cases.

ALTHOUGH the clinical manifestations are fairly well defined, the concepts of the origin and delineation of chronic ulcerative colitis are not clear-cut. One established characteristic of the disease is a pronounced tendency to recur. Another is the preponderant incidence among persons in the age span from adolescence to about the fortieth year. The disease has been reported occasionally in children, and the author has observed one patient with a first attack at age 61.

It is possible to differentiate as a class certain cases in which the disease is due to, or associated with, chronic infection with dysentery bacilli. Even in this group the disease cannot with certainty be ascribed to the bacillary infection alone. The same is true of cases in which there is current or antecedent amebiasis. Here the importance of secondary bacterial infection has been definitely recognized. Into another classification might be put a large residuum of cases in which primary biologic damage has been done to the colon, as by nutritional deficiency, congenital abnormality, or preceding severe infection with dysentery bacilli or amebae.

Recently in reviewing 65 cases previously reported[3, 4] as well as the histories in about 20 subsequent cases, the author was impressed with the pronounced tendency to relapse. This led to meditation on other factors which might be common to all or to a definite group of these cases and related to the incidence of relapse. Consideration of certain patients under treatment at the time brought recognition that present in each were factors of heavy emotional stress and nervous tension. Recent references in the literature emphasize this aspect of the subject.[1] Kirsner and co-workers,[2] in a survey of 100 cases, stated that in 34 per cent of them, relapses could be attributed to emotional disturbances. These investigators noted another outstanding clinical feature: The cure rate (6 per cent) was exceeded by the death rate (14 per cent).

It seems that so-called idiopathic chronic ulcerative colitis may arise on a psychosomatic basis, and while it is doubtful that this is basic in the origin of all cases, it is a possible underlying factor in all. It seems to give adequate explanation of the peculiarities observed clinically and to offer a sound basis for effective treatment. The mechanism would involve the usual spasm of involuntary muscle fibres, local and general malnutrition, and resulting interference with local circulation.

The following six summarized case histories illustrate the association with emotional factors.

CASE 1: A man, 30 years of age, was first observed April 9, 1947, with complaint of mucus and blood in the stools.

Hyposensitivity to Libman's test was noted, with low knee jerks. The abdomen was tense and thin but not tender. Sigmoidoscopic examination showed an area in the upper rectum and lower sigmoid colon of pink, ground-glass appearing mucosa, oozing blood and a considerable amount of dark gray mucus. No parasites were found and cultures of swabs grew only the usual colonic flora. Examinations of the stool showed large amounts of gross blood, gray mucus and pus cells. X-ray examination of the gastrointestinal tract showed no organic lesion although there was evidence of moderate mucosal thickening in the lower jejunum and ileum.

A clinical diagnosis of early chronic ulcerative colitis was made, and although the patient was an agreeable, pleasant person who said he was unworried and felt no nervousness, underlying neurotic factors were suspected.

Psychotherapeutic conferences elicited a story of childhood and early adolescent hostility toward the father, who was characterized as dominating, imperious and dogmatic, especially in relation to insistence that the son prepare for engineering as a profession. There was also a history of previous attacks of colitis and gastrointestinal distress associated with emotional disturbances:

1. While attending a private high school for boys the patient had had an attack of epigastric pain with severe constipation and fever. The symptoms quickly subsided.

2. A few months later dark red blood appeared in the stool with regular bowel movement. There was a slight elevation of temperature, but no pain.

3. Indigestion and abdominal discomfort followed transfer from the private high school (and abundant personal attention) to college where supervision was minimal.

4. An attack of colitis with pain, bleeding, dysentery and loss of weight occurred during the patient's second college year when a childhood sweetheart had broken their engagement to marry. The colitis persisted for two years despite dietary and medicinal therapies. Recovery was gradual but complete. The patient failed in his studies, changed schools, but still "could not stomach" the profession his father had chosen for him.

After the interview in which this story was finally crystallized, the colitis was sharply accentuated.

Soon afterward the patient was inducted into the army, where he adjusted fairly well until ordered to prepare for overseas duty. Colitis occurred again. It necessitated hospitalization, lasted ten weeks, and resulted in discharge from the army.

Subsequently, the patient became happily married. He was employed as a clerk with no professional training. However, he stated that he still had the feeling of pressure from his father.

The colitis gradually subsided and symptoms of colonic bleeding and inflammation disappeared. Although the possibility of recrudescence was explained, the patient decided against psychotherapy.

CASE 2: A 36-year old married male was first observed by the author April 19, 1948, with a complaint of severe lateral and posterior pain under the lower left ribs on inspiration. Beginning January 1, 1948, the patient had had severe diarrhea with colic preceding each of ten daily bowel movements. Nausea and vomiting were present on the first day only, and there was no gross bleeding. There was no history of earlier gastroenteric symptoms of any kind. The diarrhea gradually subsided in the next few days but did not stop entirely. In mid-February it again became worse and the patient began losing weight, had a low fever and felt weak. He consulted a physician and was hospitalized. After careful study, the tentative diagnosis was chronic idiopathic ulcerative colitis.

The patient remained in the hospital two months with fever ranging from 100°F. to 103.5°F. daily. Weakness increased, loss of weight continued, and bowel movements averaged eight to ten each 24 hours. In a proctoscopic examination an easily bleeding area on the edge of the lower rectal valve, with apparently normal mucosa above it, was noted. Cultures of stools were negative for pathogens and adequate search revealed no parasites.

When first observed by the author because of the pain in the lower left chest, the patient was hospitalized because of evidence of pneumonitis. X-ray examination confirmed this, and a further x-ray study 18 days later showed improvement. Those of the colon showed an atonic dilated organ with evidence of extensive mucosal edema and ulceration. At that time there were eight to ten bowel movements daily, with pain but no blood.

Repetition of tests and examinations that had been carried out at the time of the previous hospitalization confirmed the findings that had been noted then. Treatment consisting of blood transfusions, various antibiotics and other medication, dietary control and high vitamin intake had no effect on symptoms.

As it had been noticed that the patient was tense and highly emotional, he was discharged from the hospital and referred to a psychiatrist, who reported a high degree of dependence upon both mother and wife, with resentment toward the mother and probably toward the wife. The patient had maintained independence only with difficulty for the past several years. Struggle between dependence and independence had been enhanced by a recently developed ambivalence with regard to an executive of the firm for which he worked. The psychiatrist felt that the tension produced by these conflicts played an important role in the colitis.

In the course of several months of psychotherapy the diarrhea diminished and finally stopped. The patient gained weight and said he felt much better. He had quit his former job and after several months of idleness he took another. With adequate guidance, future good adjustment was considered probable.

CASE 3: A housewife about 25 years of age who had two children was first observed March 31, 1939, because of dysentery which had begun a month before with eight to ten bowel movements daily, attended by pain and low fever. Stools contained blood and mucus. There was history of previous attacks, one five years and another four years previously, which had been of short duration. A year later a third attack lasted two months and the patient was hospitalized. Amebae were said to have been found in the stools at that time. After lapse of another year and a half, a fourth attack occurred during pregnancy and the pregnancy was terminated. Symptoms disappeared after two months, apparently without relation to medical treatment.

The patient was hospitalized for the current illness. Upon sigmoidoscopic examination it was noted that the mucosa had a red ground-glass appearance. It bled easily, and a thin fibrinous exudate was present. No parasites were found on adequate examination and results of specific tests for bacterial or other pathogens were negative. Gastrointestinal x-rays with barium enema showed colonic spasticity only. The attack subsided in about two months but in the next several years relapses of varying degrees of severity occurred, with increasing x-ray evidence of ulcerative colitis.

Finally, in 1947 the patient was referred for psychiatric appraisal and was found to have emotional immaturity "quite typical of patients with ulcerative colitis and other colitic diseases."

CASE 4: A housewife, 37 years of age, was first observed March 16, 1945, with complaint of diarrhea, headache, extreme fatigue, frequent sore throat, indigestion, and pains in legs and feet. There was history of "chronic colitis"—severe recurring attacks of diarrhea with blood and mucus in the stool.

The patient, who was 47 inches tall, weighed 105 pounds. She was intense, anxious and poorly nourished.

Gastrointestinal x-ray studies showed only pylorospasm and persistent gastric residue. No parasites were found in the stools. There was no fever.

Interview elicited evidence of high nervous tension and emotional stresses dating from childhood, and chronic hostility toward mother and husband. In the ensuing three years there were numerous flare-ups of colitis associated with episodes of aggravated emotional tension.

In February, 1948, the patient was hospitalized because of severe colitis and prostration. X-ray studies with barium enema showed haustrations almost completely absent, and there were numerous punched-out ulcers from the upper sigmoid colon to the cecum. Proctoscopic examination showed the rectal mucosa to be normal. The temperature was 103°F. and the patient was mentally depressed and in a state of severe malnutrition. Ileostomy was done and for 15 days there was clinical improvement, moderate psychologic leavening and better food intake. Proteins, vitamins and electrolytes were given parenterally. Mental depression returned, was followed by physical relapse, and the patient died April 9, 1948.

At postmortem examination there was anatomic diagnosis of healing chronic ulcerative colitis, acute ulcerative ileitis and severe emaciation. The lesions of colitis were almost healed but considerable scarring was noted. An interesting feature was the relatively recent ulceration of the ileum. Scattered ulcers were found extending as far upward as the jejunum. Inanition apparently was the cause of death.

CASE 5: The patient, an unmarried woman 26 years of age, was first observed March 9, 1945, because of recurring dysentery, with blood and mucus in stools, and severe colic. Repeated episodes of several weeks each had occurred in the preceding year.

The patient was 66 inches tall, weighed 120 pounds and appeared to be poorly nourished, nervous, and apprehensive. Upon physical examination, tachycardia and vasomotor instability were noted. A red ground-glass appearance of the mucosa of the rectum, with many shallow irregular ulcers, was observed in sigmoidoscopic examination. No parasites were found in a study of mucosal scraping, and no pathogens developed on cultures. Skin food-antigen tests gave 1 plus positive reactions to onion, tea, potato and yeast. That

for total milk was negative. Gastrointestinal x-ray studies showed no abnormality. The basal metabolic rate was 5 plus.

Psychologically the patient was extremely insecure with great dependence on and unconscious hatred of her mother, who was exacting, meticulous, and highly possessive. The patient was fearful, and this culminated, as her marriage approached, in panicky fear of marriage and increased feelings of guilt toward her mother. Psychotherapy largely dissipated the guilt, fear, hatred and dependence so that she entered marriage normally and has had to date only one short and mild attack of colitis. The improvement has been remarkable as the patient's independence, insight and security have increased.

CASE 6: A 28-year-old married woman with no children was first observed September 28, 1943, because of dysentery (12 bowel movements daily) with much blood, mucus and pain. The patient had had life-long constipation with attacks of diarrhea. After scarlet fever at age 7 she had attacks of dysentery lasting for weeks or months. The patient had always disliked milk, and it caused indigestion if drunk in more than minimal amount. Eating spiced, fatty and fried foods also caused gastric distress. Many stool examinations over the years had never confirmed suspicion of amebic dysentery. The patient had not lost weight and at no time was fever present.

General abdominal soreness was noted. The blood pressure was 100 mm. of mercury systolic and 72 mm. diastolic. Erythrocytes numbered 3.5 million with hemoglobin value (Sahli) of 54 per cent. Leukocytes numbered 4,800 with 57 per cent granulocytes and 39 per cent lymphocytes. Gastrointestinal x-ray studies gave evidence only of chronic colitis, especially of the descending colon. Roentgenologic studies of the gastrointestinal tract in 1946 had shown no abnormality, and studies with barium enema showed no evidence of colitis.

In psychiatric appraisal, rage against the father, with repeated death wishes, was noted. The patient had a panicky fear of her father which was associated with his addiction to alcohol. This animosity, which extended back to early childhood, was extended later to the patient's husband. Attacks of dysentery, associated with colonic hemorrhage, severe colic and nausea, recurred irregularly until January, 1948, when psychotherapy was instituted. No exacerbations have occurred since.

DISCUSSION

It is to be noted that in the first 35 cases of chronic ulcerative colitis reported by the author, 17 of the patients were definitely neurotic. In the second report, covering 30 cases, it was noted that "allergic and psychologic" features were prominent. All the patients in the six cases reported herewith had pronounced emotional disturbances. Kirsner, and co-workers[2] stated: "The tendency toward exacerbations and remissions of symptoms is one of the characteristic features of nonspecific ulcerative colitis. It is possible to attribute the relapses in this series to emotional disturbances in 34 per cent (of 100 cases); to infections of the respiratory tract in 29 per cent, and to physical fatigue in 14 per cent. However, these represent several of the more common difficulties in life, and, hence the relationship may be more accidental than causal. Indeed, relapses seem to occur with any form of stress and to be a reflection of a labile intestinal response."

It would appear that psychodynamic appraisal of the patient were an essential part of diagnostic study in each case. This is more important than search for parasitic, bacterial or allergic factors. Demonstration of Endameba histolytica, dysentery bacilli, or neoplasm at once removes the case from the category of idiopathic ulcerative colitis.

TREATMENT

Psychotherapy should be instituted early. It must be skillful and often it may have to extend deep into the emotional substrate.

It is always to be remembered that when organic evidence of colitis is present, the colitis must be treated as a thing in itself, while psychotherapy reaches far deeper and aims at prevention of recurrence.

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Diagnosis and Differential Diagnosis of Poliomyelitis

The Management of Patients in the Hospital Admitting Room

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SUMMARY

Because of the great variety of early symptoms of poliomyelitis and their similarity to the symptoms of a number of other diseases, in times of epidemic many patients are admitted to hospital on suspicion of poliomyelitis. At such times the prime purpose of the hospital admitting room staff is to distinguish between patients with poliomyelitis (or other diseases requiring immediate treatment) and those who may be referred into other channels.

This presentation (1) points out the superficial similarities of the clinically observable signs and symptoms and of laboratory data in poliomyelitis and in other diseases, and (2) discusses the more occult dissimilarities which aid in differentiation.

DURING an epidemic, for every case in which poliomyelitis is diagnosed and the patient is admitted to hospital for that reason, there are four or five in which patients who do not have the disease are examined because of symptoms which simulate those of poliomyelitis. At such a time, the prime purpose of the admitting room is to admit patients with poliomyelitis and such others as warrant additional study, and to refer all other patients into channels providing for further diagnosis and treatment. The admitting room should be provided with the necessary personnel and equipment to make the distinction and to handle any emergency. Respirator, suction apparatus and oxygen are vitally necessary.

When the patient enters the admitting room of the Los Angeles County Hospital, his parents or other relatives are given a brochure which explains in detail what is going to be done with the patient, what laboratory procedures are to be performed, what the administrative policy of the hospital is, what care should be given contacts at home, what the quarantine regulations are, and other useful information of the kind. This brochure, written in non-technical language, is most effective in controlling the anxiety of the parents or other relatives and in saving the time of the attending physicians and nurses.

A complete and thorough history is important and is written in the admitting room. It includes the following:

1. Chronological listing of all symptoms from onset, with emphasis on fever, headache, sore throat, diarrhea or constipation, muscle spasm, pain and weakness.

2. History of contact with persons with poliomyelitis in the family or neighborhood.

3. History of unusual physical exertion, fatigue, chilling, or exposure.

4. History of recent operation in the upper respiratory tract.

5. History of illness during the previous month.

6. History of past muscular, neurological, pulmonary or cardiac disease.

A complete and thorough physical examination is essential in diagnosing poliomyelitis. Particular emphasis is placed on the following points:

1. Stiffness of the neck, back or hamstring muscles. The Brudzinski, Kernig and spinal signs are important if positive. Hoyne's head drop sign is indicative: When the shoulders are lifted off the bed the head falls back due to weakness of the anterior neck muscles. This head drop sign is found in other diseases causing meningismus but is frequently found in severe poliomyelitis.

2. Reflex changes. Attempt is made to elicit Babinski, Chaddock and Oppenheim reflexes, and the reflexes of ankles, knees, biceps, triceps, cremasters, abdominal, spinal and gluteal muscles are examined. Absence of reflex or difference in response between the two sides is confirmatory evidence. The presence of pathological reflexes referable to the upper motor neuron, such as the Babinski, is contraindicative of poliomyelitis as a rule.

3. Muscle weakness. By various maneuvers muscles can be tested for strength. Weakness present may range from mild to complete. Not only must the extremities be tested, but the strength of the intercostal muscles and diaphragm must be estimated, and the function of the muscles of the neck, palate, pharynx, larynx, face and eyes must be appraised. Especial diagnostic import is placed on the presence of head drop indicating weakness of the sternocleidomastoid muscles.

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4. Sensory changes. Mild hyperesthesia may occur in poliomyelitis, but anesthesia, paresthesia, or sensory changes at definite vertebral levels preclude the diagnosis in nearly all cases.

5. Changes in the throat. In many cases there is mild to moderately severe injection of the pharynx.

Laboratory procedures routinely carried out while the patient is in the admitting room are complete blood cell counts, urinalyses, and spinal fluid examinations. The spinal fluid is examined for initial pressure, number of cells present per milliliter, types of cells seen in stained smears, the protein content (Pandy test), and quantitative sugar. In addition, specimens are saved for culture, for determination of chlorides, and for Wassermann test. At the discretion of the physician, additional procedures may be done. A partial list includes blood cultures, blood chemistry determinations and x-ray studies.

Until such time as a quick, accurate, specific laboratory test becomes available, the diagnosis of poliomyelitis must depend upon the clinical evaluation of the history, symptoms, physical signs, and laboratory aids currently available. Since the clinical picture may vary greatly, intimate knowledge of what poliomyelitis does and does not do is a necessity in judging each case.

Clinically poliomyelitis may be divided into three main categories: (1) the abortive; (2) the non-paralytic; and (3) the paralytic.

Poliomyelitis of the abortive type is mild in character and of short duration. The symptoms are referable to the upper respiratory tract (such as sore throat) or to the gastrointestinal tract (such as constipation or diarrhea) but there is little evidence of central nervous system involvement, such as meningism, muscle spasm or muscle weakness. The majority of poliomyelitis cases falls into this category, but for practical purposes it is impossible to diagnose the abortive type except by inference on an epidemiological basis.

Non-paralytic poliomyelitis differs from abortive poliomyelitis in that physical signs and laboratory findings are indicative of central nervous system involvement, namely: (1) Meningeal signs (stiff neck and back, positive Kernig, Brudzinski, and spine signs; (2) varying degrees of muscle spasm; (3) changes in superficial and deep reflexes; and (4) the presence of abnormal spinal fluid findings. The muscles most frequently tight are the hamstrings, back and neck muscles, posterior calf muscles, pectoral and other muscles of respiration, quadriceps femoris and biceps brachialis. Reflexes are found to be absent, diminished, or unequal. Non-paralytic poliomyelitis, which is most difficult to diagnose because of the similarity of symptoms to those of other disease entities, accounts for about 65 per cent of the recognizable cases observed during an epidemic.

Paralytic poliomyelitis differs from the non-paralytic in that muscle weakness is also present. Weakness is of the flaccid or lower motor neuron type and may range from mild paresis to complete paralysis either in isolated muscle groups or complete paralysis of large segments of the body. This involvement of isolated muscle groups with varying degrees of weakness is an important distinguishing feature of paralytic poliomyelitis.

Anatomically, paralysis in poliomyelitis may be classified as spinal, bulbar, encephalitic, or as combinations of these, such as bulbospinal. Highest in incidence is the spinal type, recognized by involvement of the extremities or trunk. The lower extremities are much more frequently involved than the upper. With extensive involvement of the lower extremities, paralysis of the urinary bladder and rectum is not infrequent. With extensive involvement of the upper extremities the intercostal muscles and diaphragm are often involved. Associated with weakness are a diminution or abolition of deep reflexes and early disappearance of superficial reflexes. The Babinski, Chaddock, and Oppenheim reflexes are always negative in this type.

Bulbar poliomyelitis is recognized by involvement of the cranial nerves, cardiac, and respiratory centers. It may occur alone or in conjunction with involvement of the spinal cord and encephalon. Any cranial nerve may be involved but the nerves most frequently affected are the sixth, seventh, ninth, tenth, eleventh, and twelfth. Tenth, eleventh, and twelfth nerve involvement is usually bilateral. Ten to 20 per cent of the cases of poliomyelitis are of the bulbar type.

Encephalitic poliomyelitis is much less common. Stupor or delirium, hyperpyrexia, and profound toxemia are present in this type. Convulsions may occur and there may be paralysis of an upper motor character with spasticity instead of flaccidity, hyperactive reflexes and a positive Babinski sign. Involvement of the medulla and the presence of bulbar signs are usually associated with encephalitic poliomyelitis.

Knowledge of the onset, of expected febrile course, and of signs and symptoms other than those already mentioned is of value in determining the final diagnosis of poliomyelitis. Study of the febrile course is especially important. In approximately 20 per cent of the cases, and principally in children, there is a biphasic fever curve. There is a short initial febrile period of several days' duration, with nonspecific symptoms, which is followed by a fever-free period of a varying number of days (usually two to four), and then a second period of fever accompanied by signs and symptoms of central nervous system involvement.

Chills and chilly sensations are observed at the onset of bulbar involvement in 10 to 15 per cent of the cases, and in 2 to 4 per cent at the onset of spinal involvement. The duration of the febrile phase of uncomplicated poliomyelitis varies from one to 14 days. (In the biphasic type, duration commonly is counted from the onset of the second period of fever.) The configuration of the fever chart approximates a sine curve with a gradual rise to a plateau and a gradual fall. A "septic type" of fever curve indicates complications.

The majority (approximately 80 per cent) of non-paralytic cases run a febrile course of one week or less, and only a small number of patients (4 per cent) are febrile 10 to 14 days. Patients with paralytic poliomyelitis tend to have fever for longer periods; approximately 50 per cent continue to have elevated temperatures into the second week or beyond. In non-paralytic and in spinal types of poliomyelitis, maximum temperatures in 90 per cent of cases range from 100° to 103° F.; temperatures of 105° F. are rare. In bulbar and encephalitic poliomyelitis temperatures to and exceeding 105° F. are not too uncommon, temperatures of 104° F. and above being recorded in about one-third of the cases.

There is no correlation between the height of fever and the degree and amount of muscle tightness or weakness. However, there is a close correlation between duration of fever and the percentage of paralytic cases and the severity of paralysis and muscle spasm.[5]

Patients with febrile courses up to one week show weakness in about 25 per cent of cases; 50 to 60 per cent of those with fever continuing into the second week show weakness. The longer the duration of fever, the more likely is the occurrence of paralysis.

Severe weakness (3 plus to 4 plus on a scale of 1 to 4) is observed in about 15 to 20 per cent of patients running febrile courses up to one week, whereas it occurs in about 50 per cent of those with fever continuing into the second week. Patients with paralytic poliomyelitis who have fever for nine to 14 days almost inevitably have severe degrees of weakness in the muscles involved. The longer the fever persists, the more severe is paralysis liable to be.

Similarly, severe muscle spasm (3 plus to 4 plus) occurs in about 30 per cent of cases in which the patient has fever for periods up to one week; in cases in which fever persists into a second week, severe spasm occurs in approximately 45 per cent. Extension of paralysis ceases when fever subsides; infrequently extension of weakness may occur after the patient becomes afebrile.

Muscle spasm persists for a variable time after fever leaves. This aids in distinguishing between meningeal irritation and tightness of the posterior neck, back, and thigh muscles. The former subsides as the patient becomes afebrile, whereas muscle spasm may persist for weeks after the fever abates, and even may become more severe unless treated.

Sensory changes occur in poliomyelitis, but they are limited. Moderate hyperesthesia at the onset is occasionally observed. Paresthesia is exceedingly rare. Anesthesia and sensory levels do not occur. Pain in the muscles increased by motion is frequent.

The most ominous sign—and the cause of most of the deaths—in poliomyelitis is impaired respiration. This may be due to a variety of factors: (1) Palatal and pharyngeal paralysis allowing accumulation of mucus and saliva in the throat, thereby obstructing the airway; (2) paralysis or severe spasm of the intercostal muscles and diaphragm; (3) atelectasis; (4) disturbance of the respiratory center; (5) laryngeal paralysis or spasm.

Most patients will complain, at the onset, of headache, frontal, occipital or parietal in location. This is of especial significance in diagnosis of poliomyelitis in children, for they rarely complain of headache as a presenting symptom in most other diseases. Two other signs worthy of note are the disproportionately rapid pulse rate for the degree of fever, and the clear sensorium excepting in severe bulbar or encephalitic cases.

Of great diagnostic aid is examination of the spinal fluid. This is especially helpful in diagnosing the obscure mild case. Occasionally several examinations of the spinal fluid are necessary, after a suitable interval, to note any changes. Abnormal changes in the spinal fluid are present in 80 to 90 per cent of recognizable cases of poliomyelitis—in some epidemics more, in others less.[9] There is usually an increased number of cells, the number ranging from 10 to 200 cells. At times as many as 1,000 to 2,000 cells are found, but this is uncommon. The cells are predominantly lymphocytes except in the early days of the disease, when neutrophils often predominate. Associated with the increased cell count is a moderately increased content of protein in the spinal fluid.[3] Great increases in protein are unusual. The spinal fluid chlorides and sugar levels are normal (sugar content should always be determined). No organisms are found. The pressure is usually moderately elevated, rarely it is very high, and often normal or low. It is well to note that in both paralytic and non-paralytic poliomyelitis, the results of spinal fluid examination may at times be within normal limits.

Count of leukocytes in the blood and determination of sedimentation rate are of diagnostic aid. The leukocyte count ranges from 2,500 to 25,000, but counts below 4,000 and above 20,000 are unusual. Leukocyte counts have been noted to vary somewhat from place to place and even in the same locale from year to year. For example in 1943 in Los Angeles, counts of 16,000 or above were observed in only 5 per cent of the cases. In 1948 such counts were noted in 19 per cent of the cases. The average count in 1943 in Los Angeles ranged from normal to somewhat low. In 1948 the average count was moderately elevated. There was no correlation between the leukocyte count and the degree of paralysis or the severity of the illness.

In most cases of poliomyelitis, the sedimentation rate is accelerated. The increase is mild (from 1 to 13 mm. above normal at the end of one hour) and in most cases the rate reverts to normal within two to three weeks after the febrile period.[4] When corrected for fever, this increase is less. There is no appreciable difference between the sedimentation rate for patients with paralytic poliomyelitis and the rate for patients with the non-paralytic form of the disease.[7]

Because the symptoms, physical findings and laboratory findings associated with poliomyelitis are so variable, the differential diagnosis is necessarily

complex. During the 1948 epidemic in Los Angeles, patients with 75 different clinical entities were sent to the hospital because of suspicion of poliomyelitis. Diseases that produced the following findings were suspect: (1) Weakness or painful movement of the extremities; (2) spasm of neck, back or hamstring muscles; (3) asymmetry of superficial or deep reflexes; (4) difficulty in breathing; (5) difficulty in swallowing; (6) stupor or convulsions; (7) weakness of the extraocular or facial muscles; (8) abnormal findings in the spinal fluid.

Often the true diagnosis may be made quickly in the admitting room by careful history-taking and physical examination.[8] It may be found that the apparent weakness is actually the result of trauma—for example, a fracture or dislocation. Or difficulty in swallowing may be traced to the presence of a peritonsillar abscess or of a foreign body. Difficulty arises at times from inability to make adequate appraisal of the physical condition, particularly in the case of an infant or small child, because of resistance to examination. A period of observation then is necessary.

There are, however, some cases in which the neurological findings are such that further observation of the course of the disease and further laboratory tests are necessary before it is possible to establish the correct diagnosis. The following are some of the conditions which may give rise to symptoms which may at first be similar to those of poliomyelitis: tuberculous, purulent or viral (mumps, etc.) meningitis; encephalitis other than that due to poliomyelitis; influenzal syndrome; rheumatic fever; infectious neuronitis (Guillian Barré), and meningismus (especially when due to lobar pneumonia or bacillary dysentery).

Tuberculous meningitis is often more difficult to differentiate from poliomyelitis than any other single entity not only because it presents a picture of central nervous system involvement, but also because associated with it are spinal fluid changes that superficially resemble those of poliomyelitis. The course in the untreated case is one of progressive deterioration of the patient, ending in death. In this disease the spinal fluid shows (1) a consistently low sugar level, (2) chlorides of 500 mgm. per 100 cc. or less, and (3) acid-fast organisms on smear or culture. Other confirmatory evidence can be obtained usually by x-ray of the chest and tuberculin skin test.

Because delay in treatment is fraught with danger, purulent meningitis is the most important disease to be differentiated from poliomyelitis in the admitting room. In a typical case of acute meningitis the patient is seriously ill, the onset of meningeal signs is abrupt, the sensorium is confused, the superficial reflexes react symmetrically, and convulsions are not uncommon. The spinal fluid is cloudy to milky in appearance; and if the disease is caused by bacterial infection, the causative organism often can be quickly demonstrated by direct smear or culture unless the patient has received doses of antibiotics or chemotherapy. In the event of an epidemic, however, in which spinal fluid cell counts in many true cases of poliomyelitis range from 500 to 1,500 (mainly neutrophils in the early stage of the disease), differentiation becomes far from simple. A factor that may be of help in this regard is the decreased sugar content in the spinal fluid in meningitis. Mention should be made of two cases of poliomyelitis observed by the authors in which there were petechial hemorrhages, although this sign is generally considered as indicative of meningococcemia. Special note should be made of the occasional cases of influenzal meningitis in which, early in the course of the disease, there are a few hundred cells in the spinal fluid, predominantly lymphocytes, and only slight neck rigidity. The differential diagnosis is further confused by the occasional case of poliomyelitis in which there is severe opisthotonos and the spinal fluid contains 1,500 cells. Between these two last noted extremes occur the most perplexing problems that confront the diagnostician.

Although there are many viral diseases capable of producing spinal fluid pleocytosis and a clinical picture indistinguishable from non-paralytic poliomyelitis, the one most common is mumps. The diagnosis is simple in the presence of parotid swelling, but occasionally the swelling precedes the onset of meningitis by a week or two. Sometimes it does not occur until after symptoms of meningeal infection appear. In some cases there may be no parotid swelling at any time. In cases of mumps meningoencephalitis without salivary gland involvement, diagnosis must depend solely upon a rising complement fixation titre or upon results of an agglutination inhibition test. Prolonged observation often is necessary to establish the diagnosis.

In the case of viral encephalitis such as Economo's disease, or equine or St. Louis encephalitis, laboratory virus studies, usually with paired sera, are necessary to confirm the diagnosis. Howe[6] has pointed out that when encephalitic signs are accompanied by flaccid paralysis of the extremities the diagnosis of poliomyelitis is relatively secure.

Muscle spasm may be simulated by the myalgia of influenza but careful examination should reveal that the muscle pain is accompanied by guarding rather than actual spasm. In influenza the muscle spasm does not persist after the fever has subsided as it often does in poliomyelitis. Also the headache present in influenza will usually respond to analgesics while the severe headache often occurring in poliomyelitis responds only to lowering of the spinal fluid pressure by lumbar puncture.

Rheumatic fever in which there is involvement of the spinal column and extremities without obvious swelling and redness rarely may be confusing. Again the apparent weakness and tightness are due to voluntary guarding against painful motion of the involved joints. Local diseases or injury, especially osteomyelitis, aseptic necrosis, epiphysitis, fractures and dislocations may on occasion produce muscle spasm of the back and hamstring areas, and a lum-

bar puncture and x-ray study may be necessary to rule out poliomyelitis.

Weakness of the extremities and trunk occurs in infectious neuronitis, and this syndrome must be considered as a diagnostic possibility in many cases of paralytic poliomyelitis. The absence of fever, symmetrical distribution of the weakness, and the typical albuminocytological disproportion in the spinal fluid *early in the disease* aid in diagnosis.[1] It should be pointed out again that absence of cells in the spinal fluid and protein content of 80 to 120 mg. per 100 cc. is not too uncommon in poliomyelitis. Weakness of the cranial nerves requires consideration of possible brain tumor or abscess, diphtheritic polyneuritis, or, in children, a post-convulsive state following a febrile convulsion due to an acute illness.[2] In the latter the neurological findings are usually quite transient.

Meningismus (signs of meningeal irritation without pleocytosis) is most commonly a concomitant of tonsillopharyngitis and otitis media in children with high fever. Pneumonia, especially affecting the right upper lobe, often may cause symptoms somewhat similar to those of poliomyelitis, but the higher fever and the clear spinal fluid are of aid in differentiation. In small children, if findings on clinical examination of the chest are equivocal, roentgen study may be necessary. Bacillary dysentery in its early stages before the onset of diarrhea, when patients have fever, delirium, stiff neck and stiff back, may be confused with poliomyelitis.

Some mention should be made of cases of hysteria and anxiety neuroses. These are frequently very difficult to diagnose early, especially during an epidemic when the signs and symptoms of poliomyelitis are published in many newspapers and magazines.

Grateful acknowledgment is due Dr. Albert G. Bower for his suggestions and encouragement.

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Endemism of Coccidioidomycosis in the Paraguayan Chaco

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SUMMARY

Skin testing of 541 men with coccidioidin was carried out in an investigation of endemism of coccidiodomycosis in the Paraguayan Chaco. In two areas where the climate is hot, dry and windy, positive reactions developed in a considerable number of the employees of an oil company who were of various racial origins, as well as among native Indians. In a third area, where rain is more plentiful and vegetation lush, only 2 per cent of 250 Indians tested had positive reaction to coccidioidin.

THE geographical distribution of coccidioidomycosis is related principally to hot, dry, windy and dusty areas where little rain is encountered.[1, 6, 7, 9] Identification of clinical cases in a given area arouses suspicion of endemicity; and if positive reaction to skin tests with coccidioidin, the validity of which has been generally recognized in the United States for such investigation,[1, 2, 8, 9] develops in a substantial number of residents tested, then the suspicion is confirmed.

Two clinical cases have been identified within the personnel of the Union Oil Paraguay,[4] a company which has worked in the Paraguayan Chaco for some four years. These two cases were encountered in persons living in the central zone of the Paraguayan Chaco (Zone B, Figure 1), where the climate is typical of endemic areas. The discovery of the two cases led to a survey with a view to establishing an index of probable coccidioidal infection within the personnel of the company.*

With a view to covering the three characteristic zones of the Chaco (Figure 1), the survey included a group of Guazurangue Indians, typical inhabitants of the north and northwestern zone of the Chaco (Zone C, Figure 1), also a group of Lengua Indians, who inhabit the southeastern part of the Chaco (Zone A, Figure 1).

TOPOGRAPHIC AND CLIMATIC CHARACTERISTICS OF THE PARAGUAYAN CHACO

The "Chaco Boreal" or "Gran Chaco Paraguayo," generally speaking, is a vast, flat area except for a few small hills in the northern part, the most prominent of which, Cerro Leon, is some 35 kilometers long, 20 kilometers wide and 600 meters high. The climate is hot and arid, with temperatures reaching 45° C. (112° F.) or more. The wind, predominantly from the north, blows constantly and with considerable force the major part of the year. Rains begin in October, predominate in December and January, and gradually diminish in the following months, becoming rare after the month of May.

From the point of view of topographical and physical characteristics, the Chaco may be divided into three well defined zones; the southeastern (A), the central (B), and the northwestern (C) (see Figure 1).

Zone A. This zone is of generally lower terrain, susceptible to flooding in the rainy seasons and in the periods of overflow of the Pilcomayo and Paraguay rivers. The flora consist principally of extensive palm groves and tall grass, with a scattering of quebracho and other varieties of large trees. A large part of this zone is owned and inhabited by cattle ranchers, and the fertile soil is irrigated by numerous small streams and lagoons formed by the local rains which are, generally speaking, more prevalent in this area (55 to 65 inches per year). Numerous tribes of Indians inhabit this zone, among them the Lenguas who are found throughout the section from Puerto Casado to the Monte Lindo River.

Zone B. The soil of this zone, although sandy in places, is essentially a clay. In general the zone is heavily wooded and has an erratic growth of spiny underbrush and cactus, but there is no grass to prevent the easily pulverized clay powder from being blown by the strong north winds. This is particularly true of all sections where dirt roads exist or the brush has been cleared—in other words, all the areas which are populated.

This zone is very arid and windy. Annual rainfall is from 19 to 27 inches, and arroyos, rivers, and other watercourses are completely lacking. The rain that collects in small depressions or aguadas located throughout the area is the only drinking water.

Among the fauna of the area are numerous varieties of burrowing rodents as well as many sylvan animals such as deer, wildcats, pumas, pigs, and tapirs. Vinchucas (*Triatomas infestans*) are abundant, as are mosquitoes, flies and ticks.

The two principal centers of population are Mariscal Estigarribia, military headquarters of the Paraguayan Chaco, and the Mennonite colonies, 100 kilometers to the south.

Zone C. This zone is a desert, with the windblown sands accumulating to form dunes. The an-

*A staff doctor for the company, the author was in an excellent position to carry on such an investigation. Fortunately he had been corresponding with Dr. Charles E. Smith of the Stanford University School of Medicine and the Commission on Acute Respiratory Diseases of the Army Epidemiological Board, and Dr. Smith made the survey possible by sending the necessary coccidioidin and by faithfully answering even the smallest question.

nual precipitation is far below that of Zone B, and water holes are practically non-existent. Vegetation consists of a few scrubby bushes and scattered cacti. Temperatures are consistently high and a strong north wind blows almost constantly, carrying with it a powdery sand that penetrates every opening or crack.

The Guazurangue Indians are the only typical and ancestral inhabitants of this part of the Chaco. In addition there is the personnel of a small military garrison located at Irendague or General E. Garay.

It was in zones B and C that the principal exploration program of the company was carried on; and for a period of more than three years these zones were the habitat of the personnel subjected to skin tests with coccidioidin.

THE COCCIDIOIDIN SKIN TEST

The coccidioidin used in the tests was prepared at the Stanford University School of Medicine for the Army Epidemiological Board. As is known, the coccidioidin has a very high degree of specificity, and it has been definitely demonstrated that there is no cross-reaction of coccidioidin in the tuberculous. However, there is recent evidence of cross-reaction with histoplasmin.[10]

The material was diluted 1:100, and 0.1 to 0.3 cc. of this dilution was injected intradermally. Results were read 24 and 48 hours after injection. Induration over 0.5 cm. in diameter at either time was considered a positive reaction. The size of reaction indicated by symbols is the generally adopted one:

± Induration with diameter under 5 mm. or redness without induration.
\+ Induration with diameter of 5 to 9 mm.
++ Induration with diameter of 10 to 19 mm.
+++ Induration with diameter of 20 mm. or over.
++++ Necrosis.

A positive reaction, according to Smith,[8] may be interpreted as is a positive tuberculin reaction; that is, it signifies past or present infection and does not prove active infection. Sensitivity to coccidioidin, once acquired, may endure for years even in persons dwelling long outside the area in which they became infected.

INITIAL RESULTS OF SKIN TESTS

The initial skin tests were made in the month of March 1949, upon a group of 291 adult men, of whom 209 were employees of the company and 82 were Guazurangue Indians. The entire group may be considered almost exclusively as related to zones B and C of the Chaco. The results are shown in Tables 1 and 2. The duration of residence in the area by company employees who had positive reaction ranged from ten months to 17 years.

TABLE 1.—*Detail of Results of Initial Tests (Zones B and C)*

Nationality	Number of Men	Positive* Reactions No.	Positive* Reactions %	Negative Reactions No.	Negative Reactions %
Paraguayan	186	29	15.5	157	84.5
American	10	5	50	5	50
Guazurangue Indians	82	36	43.9	46	56.1
Other nationalities	13	1	8	12	92
Total	291	71	24.3	220	75.7

*Reaction was not considered positive unless the indurated area was at least 6×5 mm.

TABLE 2.—*Degree of Reaction*

Degree of Reaction	Number
++++	1
+++	6
++	26
+	38
Total	71

COMMENT

In both of the previously mentioned clinical cases of coccidioidomycosis, x-ray films of the chest were typical and erythema nodosum was present. Both patients had strong reaction to coccidioidin. In a review of filed data on patients which was conducted after the skin testing, it was found that three men who had strong positive reactions (two of them with +++ and one with ++++) had been ill within the period 1947-1949, showing symptoms of acute infections of the respiratory system. Two had had dry pleurisy which had persisted for from one to two weeks. The diagnosis at the time of illness was influenza and pneumonia, but in light of their later strong reactions to the skin test, they now may be presumed to have had primary coccidioidomycosis.

The majority of the North Americans tested had been in the Chaco for more than two years and some of them had previously worked in areas considered endemic in the United States, which might account for the high percentage of positive reactors within that particular group.

In the group of Paraguayans tested were some who had lived in the same area for many years before being employed by the company.

The Guazurangue Indians tested had lived in the north and northwestern part (Zone C) of the Chaco all of their lives.

There were no positive reactions in men who had spent less than ten months in the Chaco, although 45 of the 291 men tested had been in the Chaco for ten months or less. Hence it would appear that all those with positive reaction (with the possible exception of the North Americans who had been previously exposed) had acquired the sensitivity after a residence of some duration in the Chaco.

RESULTS IN ZONE A

After the tests in Zones B and C of the Chaco had been completed, further investigation was carried on by the same method in Zone A. As previously

pointed out, this area is completely different from Zones B and C. In Zone A the skin tests were administered to 250 Lengua and Sanapana Indians who have been domesticated and are employed by the local ranchers. All had lived in the area five years or more. Results of the tests are shown in Tables 3 and 4.

TABLE 3.—*Detail of Results of Secondary Tests (Zone A) 250 Indians Subjected to Test*

Tribe	Number Tested	Positive Reactions No.	Positive Reactions %	Negative Reactions No.	Negative Reactions %
Lengua	240	5	2	235	2
Sanapana	10	0	0	10	100
Total	250	5	2	245	98

TABLE 4.—*Degree of Reaction*

Degree of Reaction	Number
++++	0
+++	0
++	2
+	3
Total	5

COMMENT

The tests were conducted in the same manner as those in Zones B and C and the results were interpreted on the same basis. The coccidioidin used was from the same lot. It was diluted immediately prior to making the tests. The results contrast sharply

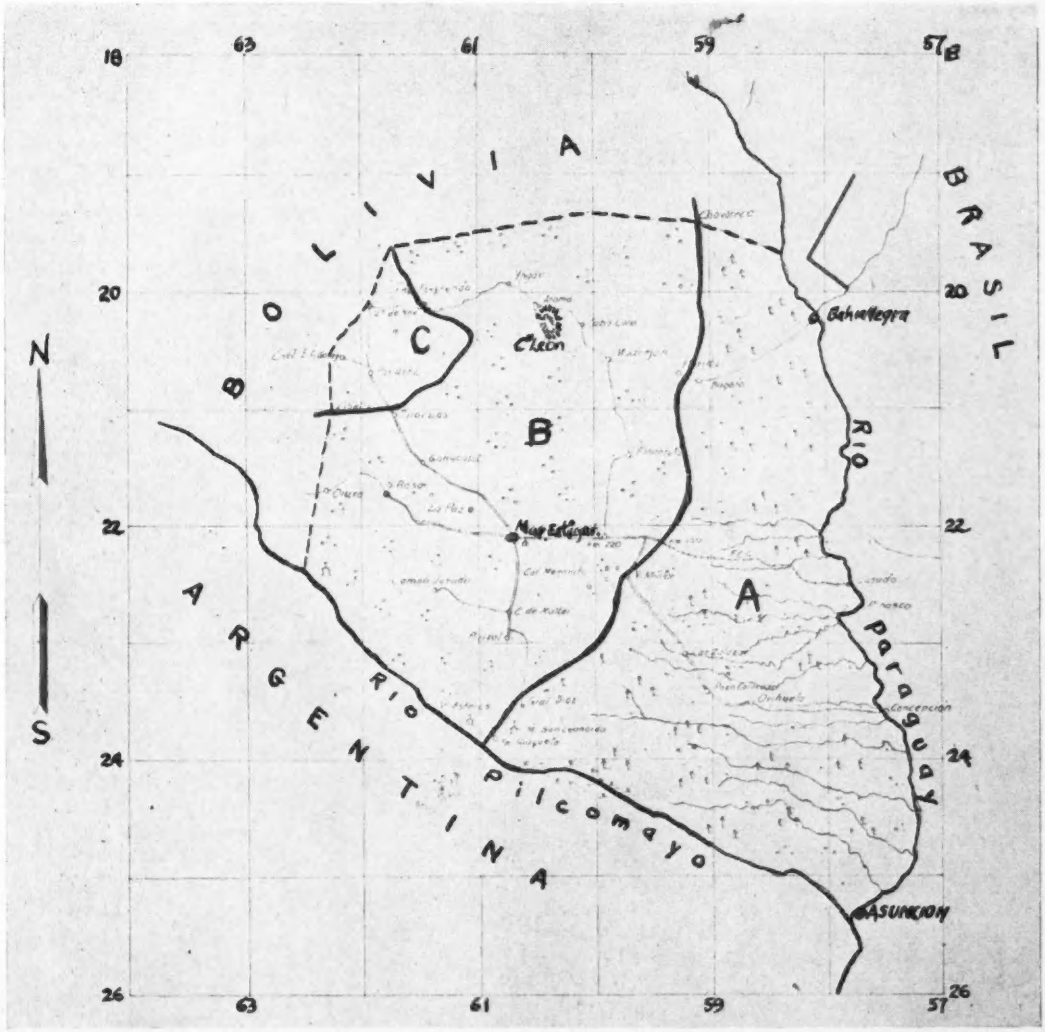

Figure 1

with those noted in the tests in Zones B and C, not only with regard to company employees but also to the Guazurangue Indians of the northwestern area. It is therefore evident that there is a well defined area (Zones B and C) where the index of coccidioidal infection is remarkably high, and it is interesting to note that the characteristics of the soil, climate and vegetation in Zones B and C are similar to those encountered in previously known endemic areas. Concomitantly, it is not surprising that Gines,[3] who recently conducted a similar survey in Asuncion, noted virtually no positive reactions in that sector.

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Cytology of the Postnasal Drip

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SUMMARY

About half of a series of 100 consecutive patients with disturbances of the eyes, ears, nose or throat complained of postnasal drip. When smears of the mucous discharge were examined it was found that in about a third of the cases in which there was complaint of drip, neither eosinophils nor neutrophils could be demonstrated. This indicates that causes of the drip other than allergic disease and infection must be considered.

Cytologic examination of the postnasal drip showed that about one-third of the patients with nasal disease or histories positive for allergic reaction had nasal eosinophilia. Nasal eosinophilia was noted occasionally in patients with normal-appearing nasal structures and in patients with no history of allergic disease.

WITH the advent of the antibiotics has come a shift in attention to the cause of chronic nasal conditions and how they may be relieved. Of fundamental diagnostic importance in this regard is the cytologic examination of the postnasal discharge. This aspect of examination has been emphasized by Hansel.[4,5] Rawlins[8] expressed the opinion that cytologic examination is absolutely essential and is diagnostic. "The finding of eosinophils in the nasal mucus," Rawlins said, "is characteristic of nasal allergy, just as the neutrophil is characteristic of infection."

OBJECTIVES

Bearing these ideas in mind, the cytologic examination of the postnasal drip of 100 adult patients with disturbances of the eyes, ears, nose or throat was undertaken as a preliminary study to throw any possible light on two questions:

1. What information on the cause of the drip might be revealed; are those complaining of the drip more liable to have eosinophils or neutrophils in the mucus than those not complaining; and, is the presence of the drip or of the cells in the drip related to evident nasal disease?

2. For clinical purposes, what classifications of patients with nasal or postnasal discharge should have a cytological examination made of the discharged material? If not all such patients, then what kind of selected patients?

Presented at the 33rd Annual Meeting of the Pacific Coast Oto-Ophthalmological Society, Coronado, California, April, 1949.

The 100 adult patients studied were observed consecutively during part of January and February 1949. A wide variety of eye, ear, nose and throat disturbances was represented. Routine examination of the nose and throat was done in all cases.

For the cytologic examination, the mucous discharge was collected more often from the pharynx or nasopharynx than from the nose. One specimen was taken from each patient and split so that two or three smears were made from the same specimen. One of the smears was stained and examined by the Hansel technique.[6] The duplicates were stained and examined by other methods.

Records were kept on each patient regarding any family or personal history of allergic reaction, and as to whether there was any complaint of mucus in the throat.

I. *Cause of Drip*

The results of cytologic examination (Table 1) showed that 18 per cent of all patients had nasal eosinophilia. The nasal eosinophilia and neutrophilia were noted a little more often among those complaining of the drip. This indicated only a trend, however, because there were not enough cases to warrant definite conclusion that allergic reaction and infection are related to the complaint of mucus. Moreover, the complaint was subjective; and subjective data may be at variance with physical or laboratory data.

TABLE 1.—*Relative to Cause of Postnasal Drip*

	No. of Cases	Nasal Eosinophilia	Nasal Neutrophilia
All patients	100	18 (18%)	54 (54%)
Complaining of mucus	50	11 (22%)	34 (68%)
Not complaining of mucus	50	7 (14%)	20 (40%)

Bryant[2] in 1949 emphasized infection and allergic disease as causes of the postnasal drip. Many other causes, including enlarged turbinates, candy eating and subthyroid states, were discussed. In this regard, the records in the present study show that in 14 of the 50 cases in which there was complaint of mucus, the mucus contained neither eosinophils nor neutrophils (see Figure 1). Also the complaint of mucus was only a little more prevalent among patients who had nasal disease than among those with no nasal disease (Table 2). The results of cytologic examination thus suggest that something besides allergic reaction and infection must be looked for to explain the cause of the drip.

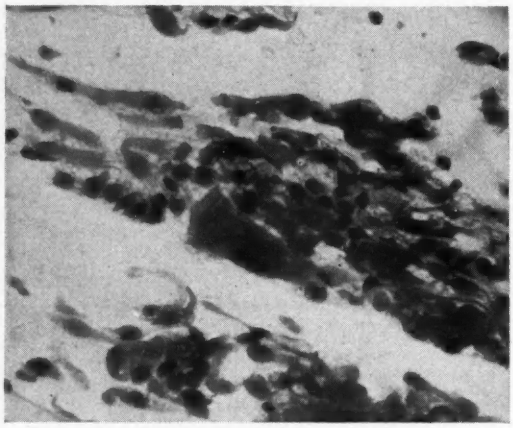

Figure 1.—Typical smear of postnasal discharge of "clear mucus," showing desquamated epithelial cells but no eosinophils or neutrophils.

TABLE 2.—*Relative to the Diagnostic Importance of Eosinophils, Neutrophils and Rhinoscopy and History*

Condition	No. Cases	Nasal Eosinophilia	Nasal Neutrophilia	Complaining of Mucus
No nasal disease	53	3 (5.6%)	16 (30%)	23 (43%)
Nasal disease	47	15 (32 %)	38 (80%)	27 (57%)
History of allergic reaction	38	12 (31 %)	....	....
No history of allergic reaction	60	4 (6.6%)	....	....
No nasal disease or history of allergic reaction	37	2 (5.4%)	....	....

One consideration is the effect that the various psychosomatic stresses to which the individual is so often subjected may have on the nasal mucosa.

Recently, Goodell and Wolff[3] reported two patterns of disturbance of nasal function brought on by emotional stress. Vasoconstriction accompanied fear or grief; hyperemia with hypersecretion accompanied anger and frustration. They reported that, "In a subject with a large gastric fistula, vascular changes in the nose, under a variety of circumstances involving hyperemia or pallor, were found to parallel such changes in the mucous membrane of the stomach."

These nasal changes with increased secretion and production of mucus may in like manner follow disturbances of a physical nature, such as variations in environmental temperature and physical exertion and fatigue.

Under these varied circumstances in the absence of nasal disease, the presence of many pus cells in the postnasal mucus would not be a logical expectation. Yet, repeated or prolonged disturbances with vasoconstrictions and dilatations may often lead to local irritation, inflammation or infection, as was pointed out by Kerr and Lague.[7] Moreover, such disturbances may make nasal allergic disease harder to relieve. On this account, the importance of applied nutrition in improving the quality of the tissues, with consequent increased resistance to environmental stresses, may readily be recognized.

II. *What Patients for Cytological Examination?*

Forty-seven of the 100 patients examined had obvious nasal disease with signs of acute or chronic reactions, and eosinophilia was noted in one-third of these 47 patients. Of the 53 patients with normal-appearing noses, three had nasal eosinophilia (Table 2).

Thirty-eight patients gave histories of allergic disease; eosinophils were noted in the nasal or postnasal discharge of about a third of them. Eosinophils were noted in the smears of only four of the group of 60 patients without history of allergic disease.

There were 37 patients with no evident nasal disease and no history of allergy. Two of these patients had nasal eosinophilia.

As to just what constitutes nasal eosinophilia, the author has been largely guided by Hansel's[6] exposition:

"In view of the irregularity of distribution, it is often not possible to make an accurate evaluation in terms of percentages. We have adopted the plan of recording the cytologic findings in terms of plus-minus, 1+, 2+, 3+, and 4+ eosinophils and/or neutrophils."

The criterion of nasal eosinophilia used in this study, therefore, was the definite presence of more than an occasional eosinophil in one of a dozen or more fields, using magnification of 250. Except for four cases in which the finding was 1+, there was a finding of 2+ or more in all cases recorded as positive for eosinophilia.

In addition to eosinophils and neutrophils the mucus contained epithelial cells of different types, lymphocytes and monocytes. Should these cells be included in the cytologic examination? The answer seems to be no, for the most part.

However, the author is indebted to Benjamin[1] for his report on the presence or absence of monocytes (or mononuclear cells) in the smears in this series. The monocytes, as Sewell and Hunnicutt[9] pointed out, make their appearance predominantly as the acute infection subsides or becomes chronic. Dr. Benjamin found them in 26 per cent of smears of mucus from patients with so-called normal noses and in 50 per cent of smears from patients with nasal disease. Although this disparity in incidence might indicate that the monocytes have diagnostic importance, the cells are difficult to recognize, according to Benjamin and also Small,[10] another pathologist who looked at some of the slides. If, for instance, an epithelial cell loses some of its cytoplasm, it looks like a monocyte.

In one case in this group of 100 patients, a diagnosis of infectious mononucleosis eventually was made. It had been hoped that masses of monocytes could be demonstrated in the postnasal mucus and that a new diagnostic procedure for this disease would be established. However, the mucus contained no unusual number of monocytes.

Yet in the cytology of the drip, cells other than eosinophils and neutrophils must receive some con-

sideration, as something unusual may show up. Hansel[5] reported a case in which all fields were covered with squamous epithelial cells. This led to discovery of a branchial cyst.

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Anuria and Oliguria

Treatment by Conservative Means, Case Report, with Determination of Blood Volume and Na^{24} Space

PART II

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THE principles involved in the therapy of anuria and oliguria which relate to water, electrolyte, and acid-base balance are by no means new. For years they have been the subject of research and publications of J. P. Peters of Yale, of James L. Gamble of Harvard, and of other investigators. Thorn[132] and Bradley[13] recently stressed the importance of these therapeutic principles in the treatment of uremia. The experience of the authors has confirmed the validity of these principles.

It should be emphasized that the treatment outlined here is designed for use in already established anuria. It is not applicable during the induction of anuria by shock or circulatory failure, as these conditions demand treatment directed at augmenting the blood volume or bolstering the circulation. In short, the described treatment presupposes that, despite successful treatment of the circulatory defect or shock, anuria still persists and that time for renal repair must be gained. The value of BAL, particularly in the early phase of heavy metal poisoning, has been amply demonstrated by Longcope and Leutscher[73] and others.

AIMS OF THERAPY

1. Life must be maintained long enough to permit the resumption of kidney function; in most instances this is apparently the time it takes for the damaged renal tubular epithelium to heal.
2. In the absence of renal regulation of electrolyte and water balance and of acid-base control, these regulations must be imposed by taking advantage of the function of the sole remaining regulatory mechanism, the lung.
3. Because of the loss of renal excretory power, medications or drugs dependent on the renal route for their elimination must be given cautiously. Drugs excreted by the biliary or intestinal system or those capable of being metabolized to CO_2 and water are desirable. (See use of digitoxin under *Therapy Relating to the Heart and Circulation.*)
4. Catabolism must be retarded because of the deleterious effect of the accumulation of its unexcreted end-products. Augmentation of catabolic processes induced by vomiting, starving, fever, activity, exercise, etc., must be prevented.
5. In the postanuric phase the patient must be prevented from having a critical loss of fluid and/or electrolytes.

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DIET

Patients are given a diet as high in carbohydrate and as low in fat, potassium, and protein as is palatable (see Appendix). Sodium is restricted in the diet so that it can be more precisely controlled by direct means (infusions, etc.). Carbohydrate is used for its favorable effect in preventing fat and protein catabolism and ketosis, while proteins and amino acids are avoided because of their possible deleterious effects.[95]

Fluids included in the diet must be taken into account in calculating the patient's daily fluid allotment.

The diet is given freely in an effort to approach the caloric needs of a resting person (calculated as 25 calories per kilogram of body weight in adults).

Oral feeding is permitted unless vomiting occurs. When foods and fluids given orally result in continued vomiting, nothing is given by mouth, not even ice chips, for fear of stimulating gastric secretion and vomiting. Parenteral feeding is then resorted to. At this stage no attempt is made to fulfill caloric needs completely. Glucose alone is used for nutritional purposes. Usually only 150 gm. to 200 gm. is given daily,[40] but if the patient is in need of fluids, the opportunity is taken to give as much glucose as the fluid administration by vein will conveniently permit.

The glucose is given in a concentration of 5 to 50 per cent,* depending upon fluid requirements and the routes of parenteral administration available (see Appendix). The favorable effect of 50 per cent glucose in anuria caused by sulfa drugs is noteworthy. If possible, it should be given early in the course of anuria so caused. Parenteral amino acids are not used,[95] and serum albumin or plasma is employed only in special situations in which it is desired to increase circulatory volume.

Vitamin B complex, because of its importance to carbohydrate utilization, and vitamins C and K are employed as dietary supplements. Indications for the use of vitamin K are ill defined, since the prothrombin concentration in anuric patients with ecchymotic tendencies is not always decreased.

*Contrary to general opinion, 50 per cent glucose given slowly does not produce a significant increase in blood volume.[98] With care, the possibility of venous thrombosis usually can be avoided (see Appendix).

DIET THERAPY SUMMARY

1. A high carbohydrate, low protein, fat, sodium, potassium diet, providing 25 calories per kilogram of body weight daily, or more if tolerated, is given.

2. The diet is designed to conform to fluid requirements.

3. If oral feeding is impractical, energy requirements are partially met with glucose, 150 to 200 gm. daily, given in a 5 per cent solution by hypodermoclysis or a 10 to 50 per cent solution intravenously, depending upon fluid needs (see Appendix).

4. Vitamins of the B complex and vitamins C and K are given (see Appendix).

FLUID THERAPY

An attempt is made to keep the patient at his usual preanuria weight. Krupp[62] suggested that the patient with anuria may even be allowed to lose weight, since the oxidation of tissues must of necessity liberate water which, if excretion were normal, would result in weight loss. Since the treatment advocated here imposes an inhibition on catabolism, and since the actual rate of catabolism is not known, the authors are inclined to hold the patient at his usual weight. It can be reasoned further that if catabolism is progressing rapidly, it is better to leave fluid space for the accumulation of wastes. The extreme of this condition, pronounced edema, is undesirable, judging from the number of deaths that occur in the presence of water overloading. On the other hand, if there is doubt about the over-all hydration of the patient, fluid administration to the end-point of minimal edema would seem far safer than the risk of dehydration.

Sufficient fluid should be given daily to replace daily losses. Water loss in the absence of urine formation is mainly insensible (that of respiration and insensible perspiration). Since insensible water loss amounts to 0.6 cc. per kilogram of body weight per hour in normal subjects,[40] only this amount need be replaced in patients with anuria.

Sensible water loss, from perceptible sweating, vomiting, diarrhea, etc., may become excessive. Such loss should be quantitatively replaced with respect to volume and composition (see both *Electrolyte Therapy* and Appendix).

Fluids are given orally as long as possible. If coma or sustained vomiting occurs, fluids are administered parenterally, as described under *Diet Therapy*. If the patient is edematous from overhydration, further administration of fluids may induce cardiac decompensation and pulmonary congestion. In such case, food, which is needed to inhibit catabolism, should be provided with minimal water, as described under *Diet Therapy*.

Because of the efficiency of the large bowel in absorbing water, enemas should not be given without considering the effect they may have on the extracellular fluids (see Appendix for enemas which will not add water).

The use of a single set of accurate balance scales to weigh the patient is essential to adequate fluid management. The bathroom scales ordinarily found in homes are impractical for this purpose as they are frequently inaccurate. If the patient cannot get up, he should be weighed in recumbency with scales such as those suggested by Wangensteen.[139] At the first examination of the patient, a record of his usual weight should be obtained. Subsequent daily weighings should be made as a check upon fluid therapy. If the fluids given cause weight increase, fluids must be further restricted.

Appraisal of fluid balance may be supplemented by the measurement of plasma volume with the dye T-1824 (Evans' Blue). Changes in the measured or assumed plasma volume can thereafter be estimated from a packed cell volume determination, if a constant red cell mass is assumed (see Appendix VII).

FLUID THERAPY SUMMARY

1. Fluid intake is restricted to estimated insensible fluid loss—0.6 cc. per kilogram of body weight per hour.

2. If there is sensible fluid loss, this fluid is replaced quantitatively with respect to volume and composition (see Appendix and *Electrolyte Therapy*).

3. If the patient is edematous from overhydration when first observed, water is withheld until his weight approaches its pre-edema level. Food, and electrolytes if needed, are given with minimal water. If the use of the oral route is contraindicated, hypertonic solutions may be given intravenously.

4. Careful weighing of the patient is essential to adequate fluid management. The weight should not be allowed to exceed the usual weight by very much.

5. Plasma volume and hematocrit studies aid in evaluating fluid balance.

ELECTROLYTE THERAPY

Since in good health both concentration and pattern of extracellular fluid electrolytes are maintained within narrow limits, it is logical to assume that tissues thrive under such conditions. Therefore, an attempt is made to keep the electrolytes as near normal concentration as possible.[109]

The usual patient has had a normal electrolyte concentration and pattern previous to the initiation of anuria. The presence of anuria apparently does not in itself directly alter electrolyte balance. The organism, however, is made hypersensitive to the acquisition or loss of water and electrolyte because adjustment of both depends upon renal control.

There are certain conditions which alter electrolyte balance:

1. If the patient has received large amounts of water, or glucose in water (which contains no electrolytes), the extracellular fluids will be diluted with respect to electrolytes, and water will move into the cells in order to reestablish osmotic pressure relationships.[106, 107]

2. If he has lost fluid from vomiting, a gastrointestinal fistula, sweating, or diarrhea, the patient

will also lose a significant amount of electrolytes.

3. If the patient has received excessive amounts of hypertonic electrolytic solutions either by mouth or parenterally, the concentration of extracellular fluid electrolytes will increase.*[143] Loss of water without loss of electrolytes, as with sweating (providing the sweat is hypotonic) will also increase electrolyte concentration.

If knowledge is unavailable of the losses mentioned, or of acquistion of electrolytes or water, it is possible to make direct measurements. The average hospital laboratory is equipped to measure the serum concentration of the anions HCO_3^- and Cl^-, but it is not equipped to measure cations, such as Na^+ and K^+. Since the electrolyte structure of the extracellular fluids is built around Na, and since increases or decreases of K are so critical, it is highly desirable to measure these cations. If serum sodium cannot be measured directly, a formula devised by Hald, Heinsen, and Peters[46] for the calculation of sodium from serum bicarbonate and chloride can be used (see Appendix). In the authors' experience this formula has been useful, although it may give low values for sodium in anuria due to the accumulation of non-measured acid anions other than bicarbonate and chloride—SO_4, PO_4 and organic acids, for example.

If it is impossible to make direct determinations of the serum potassium concentration, the electrocardiographic changes due to alterations in potassium should be watched for (see *Pathological-Physiological Changes* in Part I).

PRINCIPLES OF ELECTROLYTE THERAPY

As was noted under *Fluid Therapy*, an attempt should be made to maintain the body fluids at their usual volumes. Lost electrolytic fluids should be quantitatively replaced. If body fluids have been made hypotonic because of the administration of non-electrolytic fluids, hypertonic sodium solutions should be given.[107] Since an unknown amount of water will have moved into cells during the period in which the extracellular fluids were hypotonic, the amount of sodium replacement cannot be calculated solely upon the estimated extracellular fluid volume.[107]

The authors are inclined to use sodium in the form of a salt containing an anion capable of being metabolized to CO_2, over which the lung has control, rather than an anion such as chloride over which the lung has no control (see Appendix for fluids used). Strauss,[128] in a footnote, also mentions the beneficial use of hypertonic sodium solutions.

In anuria, regulation of potassium depends on (1) control of potassium intake, and (2) control of catabolism, since tissue breakdown releases potassium into the extracellular fluid. Carbohydrate serves a twofold purpose: It prevents cell catabolism leading to potassium release, and it provides a powerful stimulus to storage of glycogen which takes potassium into cells. Sodium acts in some measure to cause removal of extracellular fluid potassium,[32] as do insulin, epinephrine, and adrenal cortical extract.[34] Since hormonal production apparently is not disturbed in uncomplicated anuria, the authors are not inclined to use hormones. Further, the administration of potassium in the presence of severe renal failure or oliguria would seem to be extremely dangerous and should be done only if careful clinical and laboratory assessment of the need has been made.[26] On the other hand, in the stage of diuresis potassium may be needed, and can be given with less fear of intoxication (see *Treatment During the Post-Anuric Stage*).

Potassium can be removed effectively from the extracellular fluids by intestinal lavage. This is well illustrated in a recently reported case.[83] In the authors' experience it has not been necessary to resort to this measure.

Calcium, which increases cardiac irritability, tends to be beneficial in the presence of potassium intoxication. Because it also tends to antagonize the tetany induced by over-rapid administration of alkaline sodium salts, it can be given to advantage preceding sodium lactate therapy. Because of the synergism between calcium and digitalis, their simultaneous use should be undertaken with caution.[152]

SUMMARY OF ELECTROLYTE THERAPY

1. Hypertonic electrolyte solutions can be given to advantage in some circumstances.
2. The concentration of electrolyte solutions used should be determined by fluid needs as well as by electrolyte needs.
3. Serum sodium and potassium concentrations should be closely followed and kept as nearly normal as possible.
4. If facilities for measuring serum sodium and potassium are lacking, sodium may be estimated from serum bicarbonate and chloride, and potassium levels may be judged from the electrocardiographic pattern.

ACID-BASE CONTROL

When the kidneys are incapable of regulating acid-base balance, the burden falls entirely upon the lungs. Because the lungs control acid-base balance through the regulation of carbon dioxide loss, diet and electrolyte administration are designed to take maximum advantage of this ability. Since anions other than HCO_3^- (Cl^-, SO_4^{--}, PO_4^{---}, etc.) depend upon the renal route for excretion, their intake is cut to a minimum. They are replaced largely by HCO_3^- over which the lung can make adjustment. The lungs, by maintaining the ratio of H_2CO_3 to $NaHCO_3$ at 1:20, are thereby able to resist changes in the pH of the body fluids.[40]

Maintenance of normal acid-base relationship consists of: (1) administration of the optimum amount of carbohydrate needed to retard fat and

*In the absence of renal function, the administration of a balanced electrolytic solution, such as Tyrode solution or 0.9 per cent sodium chloride, does not change electrolyte concentration appreciably, since the solution expands the extracellular fluid volume without changing its concentration.

protein catabolism, both of which result in acid metabolites demanding renal excretion; (2) administration of replacement electrolytes largely in the form of Na^+ combined with an anion capable of giving rise to CO_2, over which the lung has control (for example, $NaHCO_3$ or Na lactate. See Appendix). As mentioned under Electrolyte Therapy, sodium is given only if there is depletion.

THERAPY RELATING TO THE HEART AND CIRCULATION

In anuria, the differentiation of either hypoproteinemia or congestive heart failure from water overloading is difficult. On the one hand, water overloading produces signs, such as liver engorgement and pulmonary edema, indistinguishable from signs of heart failure, and on the other hand, causes an increase in plasma volume[76, 140] with dilution of previously normal serum protein concentrations. Pulmonary edema, whatever the cause, may threaten life.

The authors are inclined to give digitalis to the patient when there is any question of heart failure. Parenteral administration is used to insure accurate dosage. The authors have used digitoxin, giving 1.2 to 1.5 mg. in the first 24 hours and 0.1 to 0.2 mg. daily thereafter. With this dosage there has been no apparent intoxication.

Phlebotomy (500 to 800 cc.) and artificial phlebotomy (using venous-occluding cuffs on the extremities) has been resorted to when indicated. On occasion when overhydration was present, cell mass has been used instead of whole blood in order not to overexpand the blood volume, and yet to maintain the high oxygen carrying capacity of the blood. Aminophylline has been used for its favorable effect on bronchial spasm. (Since aminophylline is detoxified to urea, the authors have not been averse to using it.) The use of oxygen, especially with intermittent positive pressure breathing as described by Cournand and co-workers[24] and Motley and his co-workers,[90] has been helpful in combating pulmonary edema. Prolonged positive pressure breathing, however, is liable to be deleterious.

SUMMARY OF THERAPY OF HEART AND CIRCULATION

1. In anuria, it is difficult to differentiate congestive heart failure from simple water overloading.
2. Full digitalization followed by maintenance dosage seems well tolerated in anuria.
3. Both bleeding and bloodless phlebotomy with red cell replacement are useful.
4. Aminophylline may be used to advantage.
5. Oxygen therapy and intermittent positive pressure breathing are useful.

DIURETICS

In anuria of lower nephron nephrosis, the kidney is peculiarly unable to respond either to the substances which commonly stimulate diuresis or to special agents used for this purpose. Water, which in the normal subject is one of the best diuretic agents, is ineffective. Urea, commonly useful, fails even when very high blood levels are present. The ineffectiveness of acidosis is illustrated by the fact that although anuric patients frequently become acidotic, diuresis does not coincide. Consequently, the use of acidifying salts, such as ammonium chloride, sodium sulfate and the nitrates, is contraindicated. Sodium and potassium, normally powerful diuretics, fail in anuria and should be used only to fulfill their function as electrolytes. Mercury, because of its ability to produce tubular damage, appears particularly contraindicated. Xanthines logically can be used, but have proved disappointing.

SUMMARY OF DIURETICS

1. The usual diuretics are contraindicated in oliguria and anuria, with the exception of xanthines.

CONVULSIONS

The identity of the agent or agents responsible for convulsions in uremia is obscure. Convulsions are not related directly to blood urea concentration. Sodium depletion (water intoxication)[48, 118, 119] is a well-known cause of convulsions and is accompanied by cerebral edema. Since sodium depletion is often induced in the presence of anuria, it would seem likely that it is responsible for some of the convulsions in anuric patients. Lattimer[67] has commented on the fact that cerebral edema frequently accompanies anuric uremia with convulsions. (The principles of sodium replacement and the indications for using hypertonic solutions have been discussed under *Principles of Electrolyte Therapy*.)

The authors have attempted to anticipate convulsions by watching patients for the hyperreflexia and involuntary muscle jerks which often precede a convulsion. The authors use those anticonvulsant agents which are mainly dependent on the liver or lung for excretion, such as evipal, amytal, pentobarbital, or paraldehyde, and avoid anticonvulsants with strong respiratory depressant action since respiration is so important to the adjustment of acid-base balance. Anticonvulsants, hypnotics, or sedatives requiring renal excretion, such as parenteral magnesium sulfate, chloral hydrate, phenobarbital, should be used sparingly, if at all.

TREATMENT DURING POST-ANURIC STAGE

Resumption of urine flow may be gradual, or it may be sudden. With diuresis, clinical improvement is often spectacularly rapid, but it may be followed within a few days by a rapid decline, characterized by asthenia, prostration, and shock leading to death. This decline tends to be accompanied by massive urine output with specific gravity in the neighborhood of 1.010. Rapid replacement of fluid and electrolytes given in isotonic concentrations has led to dramatic symptomatic and clinical improvement.

Continued weighing of the patient and replacement of fluid to maintain his usual weight provides a good method of following him at this stage, since a sudden gain in weight following the administra-

tion of isotonic, sodium-containing fluids indicates that fluid and electrolyte needs have been more than met. In one case observed by the authors, although large sodium replacement was made without weight gain (36 grams of NaCl as 0.9 per cent solution daily), the patient lapsed into coma. He was revived and ultimately recovered following parenteral potassium therapy.

CASE REPORT

This case report is presented to illustrate the conservative treatment advocated.

The patient, a white male, aged 55 years, had oliguria and a lower nephron lesion which developed following a second transurethral resection. Presumably, the lesion was related to overly sustained hypotension and to the entry of sterile distilled water into the prostatic venous plexus when the pressure of the wash water exceeded venous pressure, as is frequently the case in the transurethral procedure.[65]

Nov. 21, 1948: The patient was admitted to the urological service of the University of California Hospital for transurethral resection of a benign hypertrophied prostate. On admission, the temperature was 36.0°C., weight 87.5 kilograms, height 193 centimeters, pulse 80, blood pressure 128 mm. of mercury systolic and 78 mm. diastolic. Aside from the hypertrophied prostate, there were no noteworthy physical findings. The blood Kahn and Kolmer tests were negative. Urinalysis showed pH 5.5, specific gravity 1.005; no reduction, proteinuria, or acetoneuria. Microscopic examination of the centrifuged urine revealed rare hyaline casts and 1 to 2 erythrocytes and leukocytes per high dry field. In subsequent examinations of urine the findings were characteristic of transurethral resection and a moderately severe lower nephron lesion. Other laboratory data will be found in Tables 3 and 4 and Figure 2.

Nov. 22, 1948: T. 36.6°C. The patient was well hydrated previous to initial transurethral resection.

Nov. 23, 1948: T. 38.8°C. Resection was begun under pontocaine spinal anesthesia. The procedure was discontinued one-half hour later because of excessive bleeding and mild circulatory shock. The patient was given a transfusion of 500 cc. of type-specific cross-matched blood and was returned to the ward.

Nov. 24, 1948: T. 37.8°C. The patient looked well. Packed cell volume was 40 cc. per cent; fluid intake was 3,800 cc.; urine output, 2,600 cc.

Nov. 25, 1948: T. 39.1°C. Fluid intake was 2,890 cc.; urine output, 3,900 cc.

Nov. 26, 1948: T. 38.6°C. There was right costovertebral angle tenderness, possibly due to pyelonephritis. The fluid intake was pushed to 4,600 cc. The urine output was not recorded.

Nov. 27, 1948: T. 37.9°C. The fluid intake was pushed to 6,450 cc. The urine output was 5,800 cc.

Nov. 28, 1948: The costovertebral angle tenderness had disappeared. The fluid intake was 4,300 cc.; urine output, 3,650 cc.

Nov. 29, 1948: T. 37.8°C. The patient was taken again to surgery and 50 gm. of prostatic tissue was removed by transurethral resection under spinal pontocaine anesthesia. A transfusion of 250 cc. of type-specific cross-matched whole blood was given. The transfusion was discontinued when a mild chill developed. It was not thought that the patient had a transfusion reaction. The lowest blood pressure recorded during operation was 85 mm. of mercury systolic and 70 mm. diastolic. After return to the ward, the patient had profuse bleeding of unknown amount requiring traction to control it. The fluid intake was 4,900 cc.; urine output, 4,000 cc.

Nov. 30, 1948: T. 37.3°C. There was much nausea and vomiting. The fluid intake was 3,250 cc.; output, emesis, 550 cc.; urine, 1,100 cc.; a total of 1,650 cc. The packed cell volume was 34 cc. per cent.

Dec. 1, 1948: T. 37.8°C. Nausea and vomiting continued. The fluid intake was 1,000 cc. of 5 per cent glucose and 100 cc. of normal saline, both intravenously, and 1,100 cc. orally, a total of 3,100 cc. Oliguria started. (Subsequent data are included in Table 3.)

Dec. 2, 1948: T. 37.8°C. The patient was doing poorly. Nausea and vomiting continued. The oliguria regimen was begun. Because of the vomiting, all food, medication, and fluids by mouth were discontinued. It was decided that the patient was mildly overhydrated and that body weight should be maintained at about 80 kg. Because the serum sodium content was depressed, 100 cc. of 1 M. sodium lactate was given in addition to the liter of 5 per cent glucose that had been given before the oliguria regimen had begun.

Dec. 3, 1948: T. 37.4°C. Blood pressure was 140 mm. of mercury systolic and 80 diastolic. Nausea and vomiting continued. No peripheral or pulmonary edema was noted. Heart sounds were of good quality. Fluid allotments were planned to meet the patient's needs. Sodium replacement was continued.

Dec. 4, 1948: T. 37.4°C. Blood pressure was 140 mm. systolic and 75 mm. diastolic. Nausea and vomiting had stopped. The patient was looking slightly better.

Dec. 5, 1948: T. 37.5°C. Blood pressure was 140 mm. systolic and 70 mm. diastolic. The patient had no nausea or vomiting but complained of headache, which was relieved with codeine (aspirin was not given because of renal failure). The heart sounds were good, the lungs clear, the liver not enlarged. Edema was not clinically perceptible.

Dec. 6, 1948: T. 37.5°C. Blood pressure was 145 mm. systolic and 70 mm. diastolic. Physical signs were unchanged. An electrocardiogram was reported as normal, with no evidence of potassium intoxication. The patient complained of headache again, especially when he read too much.

Dec. 7, 1948:. T. 37.1°C. The patient had headache with some nausea and slight vomiting, but was mentally clear. He sat in a chair for 15 minutes. Since the serum sodium content was still depressed, the needs were met with 200 cc. of 1 M sodium lactate.

Dec. 8, 1948: T. 36.8°C. No essential change. An enema was given (see Appendix).

Dec. 9, 1948: T. 37.1°C. No essential change. An electrocardiogram was normal. Blood ketones measured as acetone were 6.7 mg. per 100 cc. Unfortunately the specimen for computation of ketones was taken one-half hour after 150 cc. of 50 per cent glucose had been given intravenously.

Dec. 10, 1948: T. 37°C. No essential change. The patient read without complaining of headache. Blood volume studies were done without apparent ill effects. Oral fluids were reinstated. Subsequently, however, when the patient could not meet total fluid needs orally, intravenous supplements were given.

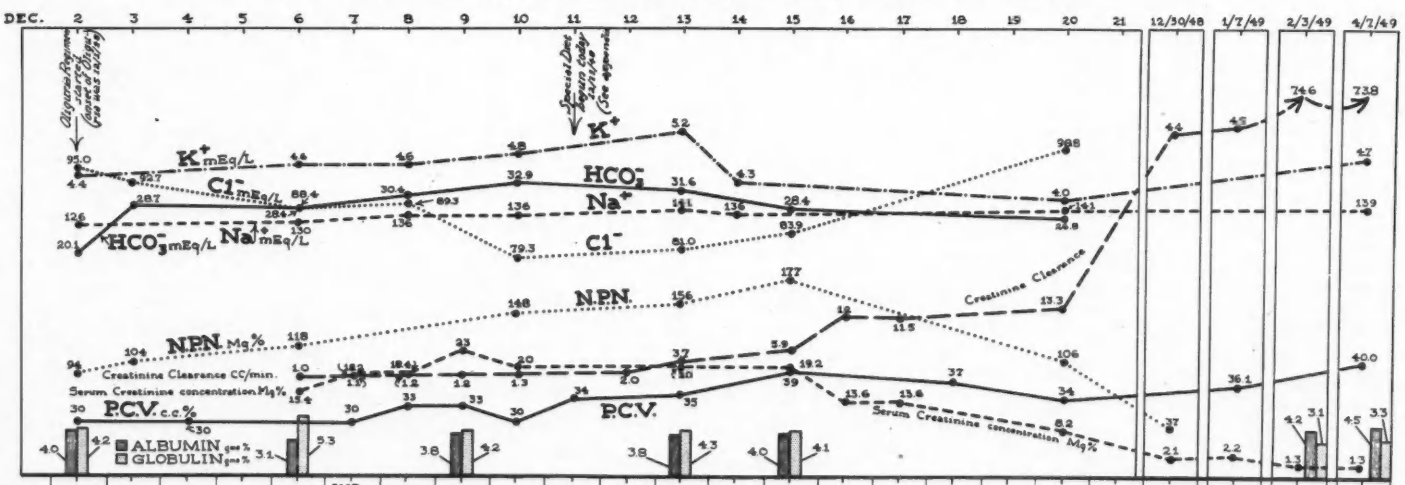
Dec. 11, 1948: The patient felt reasonably well. A special diet (see Appendix), providing 720 calories, was tried and was well tolerated. To compensate for the urinary loss of sodium, 500 cc. of normal saline was provided.

Dec. 12, 1948: T. 37.1°C. The blood pressure was 150 mm. of mercury systolic and 90 mm. diastolic. The lungs were clear. First heart sounds were reduplicated at the apex. The patient ate well (1,180 calories) and retained the food. Again, 500 cc. of normal saline was provided to compensate for urinary loss of sodium.

Dec. 13, 1948: T. 37°C. The patient was unable to eat dinner because of nausea. Diuresis started. The patient was now in excellent sodium balance.

Dec. 14, 1948: T. 37°C. The patient dangled his legs over the edge of the bed for 15 minutes; sat in a chair for 15 minutes.

TABLE 3.—*Fluid Balance and Blood Chemical Changes During a Case of Lower Nephron Nephrosis*



INTAKE	500B 100ML 1000D/W 200D10/W	1000%L 100D5/W 10C.G.	400B 150D5/W 150D5/W 150D5/W	500D5/W 500D5/W 500D5/W	1500D5/W 1000D5/W 50N.S.	500B 50N.S. 10C.G. 150D5/W 50D5/W 200ML	1125D5/W 500D5/W 50N.S. 10C.G.	300D5/W 500D5/W 50N.S.	500D5/W 150D5/W 700F	500B 500D5/W 150S 150D5/W 800F.	500D5/W 1200F. FOOD	500D5/W 150D5/W 1200F. FOOD	500D5/W 1350F. FOOD	1400F. FOOD	2505F. FOOD	2230F. FOOD	2250F. FOOD	1700F. FOOD	3050F. FOOD	3250F. FOOD			
TOTAL INTAKE	1800	1110	850	1500	1200	1460	860	850	1350	2100	1700	1850	1850	1400	2505	2230	2250	1700	3050	3250			
LOSSES URINE	300	210	175	175	210	240	350	400	480	650	800	1200	1800	2000	1580	2645	2200	1600	2450	2450			
LOSSES VOMITUS	1100	50	0	0	0	125	0	0	0	0	0	200	50	0	0	0	0	0	0	0			
LOSSES INSEN LOSS	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200			
TOTAL LOSS	2600	1460	1375	1375	1410	1565	1550	1600	1680	1850	2000	2600	3050	3200	2780	3845	3400	2800	3650	3650			
FLUID BAL.	-800	-350	-525	+125	-210	-105	-690	-750	-330	+250	-300	-750	-1200	-1800	-1275	-1615	-1150	-1100	-600	-400			
WEIGHT K.	81.8	81.0	81.5	81.0	80.8	80.6	80.8	80.8	79.5	—	80.0	81.3	80.0	78.3	78.3	77.8	79.5	79.5	76.3	76.3	80.3		83.5	86.5

Fluid balance given above represents the difference between measured fluid intake and insensible plus sensible fluid loss (urine and vomitus). As there was only one bowel movement by enema from Dec. 2, 1948, to Dec. 21, 1948, fluid loss by this means is not included in the balance figures. Because blood fulfills a special circulatory function as opposed to subserving fluid exchange from within to outside the body, it does not properly enter into the calculations of fluid exchange. Since it is reflected necessarily in the weight changes of the body, it has been included in the fluid exchanges. Water created from the combustion of administered food was not calculated into the fluid exchanges, as this seemed an excessive refinement inconsistent with the crudity of other measurement in this study.

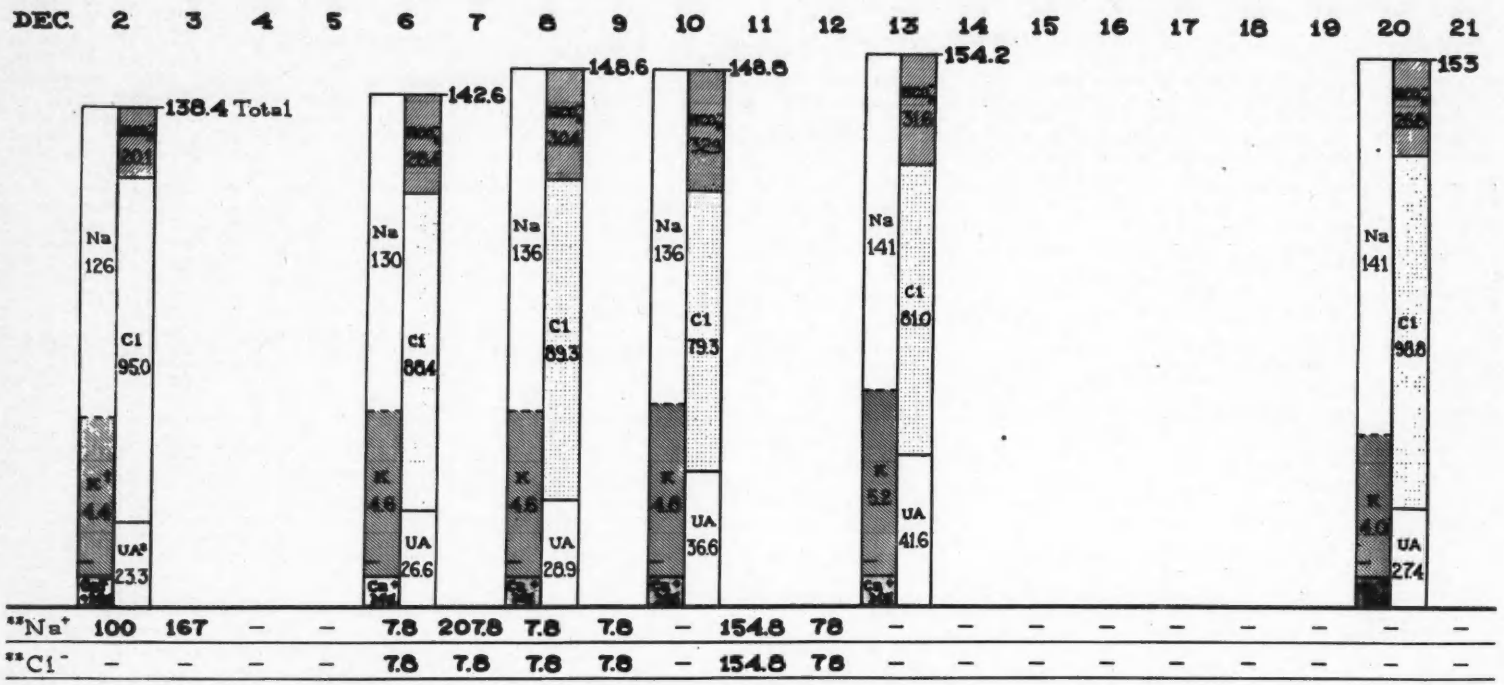
ABBREVIATIONS USED

N. S.—Normal saline (physiological)
D_5/W—The number designates the per cent concentration of dextrose in water (W); thus D_5/W is 5% dextrose in water, D_{10}/W is 10% dextrose in water, etc.
D/NS—Dextrose in normal saline
M.L.—1 molar sodium lactate
M/6 L—1/6 molar sodium lactate
F.—Fluids by mouth
C.G.—10% calcium gluconate

NORMAL VALUES FOR THIS LABORATORY

Serum albumin.....4-5.5 gm.%
Serum globulin.....1.5-3.5 gm.%
Total proteins.....6-8 gm.%
Serum chloride (Cl^-)..99.5-106.5 meq./l
Serum creatinine.....0.6-1.5 mgm.%
Endogenous creatinine clearance .....105 cc./min.
.....72-140 cc./min.
Serum potassium (K^+).....3.8-5 meq./l
Serum sodium (Na^+)....138-144 meq./l
Nonprotein nitrogen (NPN)..25-40 mg.%
Packed cell volume, (PCV):
Men .....47±7 cc.%
Women .....42±5 cc.%

FIGURE 2.—*Serum Electrolytes in Case of Lower Nephron Nephrosis. (Adapted from Table 3.)*



All figures in electrolyte columns are expressed in meq/l of serum

** Electrolytes administered during therapy expressed in meq. Loss of electrolytes in urine, emesis, etc., not measured

† Potassium column is magnified 10 times so that changes in K are more easily appreciated

* UA = Calculated unmeasured acids

‡ Ca and Mg not measured. Assumed to be constant at Ca(5) + Mg(3) = 8 meq/l

TABLE 4.—*Circulation and Extracellular Fluid*

Wt. 78.3 Kg. Ht. 193 Cm.							
Date	P.C.V. cc. %	Blood Vol. cc.	Plasma Vol. cc.	Cell Vol. cc.	Extracellular Fluid Vol. cc.	C.T.	V.P.
Dec. 10, 1948	31.5	*6950	4760†	2190		21	6.5
		*6240	4270	‡1970			
Dec. 15, 1948					§24.5 L		
Feb. 3, 1949	36.1	*6820	4360	‡2460			

*Note that the given blood volumes were calculated from the red cell volume and hematocrit in the case of the CO method, and from the plasma volume and plasmacrit in the case of the dye method.

†Cell volume measured with carbon monoxide.

‡Plasma volume measured with the dye T-1824.

§Extracellular fluid was measured with radioactive sodium (Na_{24}). 24.5 liters is 31% of 78.3 kg., the patient's body weight on this day.

C.T.: Circulation time in seconds measured with 5 cc. of 20% Decholin (arm to tongue).

V.P.: Venous pressure measured from a reference point 5 cm. beneath the sternal angle.

Dec. 15, 1948: T. 36.8°C. The patient sat in a chair for 15 minutes. Measurement of extracellular fluid volume was made (see Table 4).

Dec. 16, 1948: T. 36.8°C. Further improvement was noted. The patient was able to get up for short periods, although he still felt weak. Sodium chloride, 1 gm. three times a day, was given orally to compensate for continued urinary loss.

Dec. 17, 1948 through Dec. 21, 1948, the day of discharge: The patient was ambulatory. Although he was not strong, he felt well. Physical examination revealed no thromboses as a result of intravenous therapy. The blood pressure was 170 mm. of mercury systolic and 95 mm. diastolic but fell to 145 mm. systolic and 80 mm. diastolic on the day of discharge. Because the patient was a vegetarian, no special diet was prescribed. Except for that, however, a special diet would have been ordered until it was obvious that renal function had returned to the point where protein could be handled adequately. Often protein can be increased rapidly. Iron was prescribed, as well as sodium citrate (3 gm.) and sodium chloride (3 gm.) daily to assure sufficient sodium to compensate for renal loss.

OUTPATIENT CLINIC NOTES

Dec. 30, 1948: Blood pressure was 150 mm. of mercury systolic and 95 mm. diastolic. The patient was gaining strength, felt well, and was able to be mildly active. A gain in weight (see Table 3) was reflected in edema of the legs. Because sodium intake had surpassed ability to excrete it renally, water retention had been caused. Accordingly, sodium was discontinued. Renal function had greatly improved (see creatinine clearance in Table 3).

Jan. 7, 1949: Edema was subsiding.

Feb. 3, 1949: The patient, working in a laundry, complained of tiring easily. Creatinine clearance had improved.

April 7, 1949: There were no complaints, and fatigue had lessened. There was no further change in creatinine clearance. Packed cell volume was now near the normal (see graph in Table 3).

Oct. 6, 1949: Blood pressure was 150 mm. of mercury systolic and 90 mm. diastolic. The body weight was 90 kg. Specific gravity of the urine was 1.020; albumin, 1 plus; an occasional erythrocyte and one leukocyte per high dry field was noted. There was one coarse granular cast per low power field. Creatinine clearance was 94.3 cc. per mm. The patient looked very well and had good muscle tone.

DISCUSSION

Symptomatically, the patient had a relatively uneventful course. The vomiting which accompanied the onset of oliguria was brought rapidly under control by discontinuing oral feeding and medication. Sodium depletion was not vigorously combated but was brought slowly back to normal. The authors are inclined to meet sodium requirements gradually, thereby avoiding the risk of suddenly overloading the circulatory volume.

Potassium concentration was maintained at below toxic levels by restricting potassium intake and by following measures known to induce potassium storage and to decrease catabolism.

Fluid intake was restricted to amounts calculated to prevent gain in weight. Although this was done, it is of interest that sodium space measured with Na_{24} increased to 31 per cent of body weight (normal, 20.8 to 28.7 per cent; average, 24.8 per cent[58]). That sodium space was expanded was further suggested by the rapid fluid and weight loss with the onset of diuresis. Further, the blood volume did not share in the expansion of extracellular fluids, as it was within normal limits both during and after recovery from oliguria. It does not follow, however, that blood volume will always be static with an expanding extracellular fluid volume.[76, 140]

Ketosis and acidosis were combated by administration of carbohydrate. The lung was able to impose its regulation upon acid-base balance and did so by restraining CO_2 loss as is evidenced by a rising HCO_3^-. No particular attention was paid to the falling chloride, since the lung was able to substitute the anion HCO_3^- for Cl^- by restraining CO_2 loss. The accumulation of other anions was an unknown quantity but could be roughly estimated from the difference between serum sodium and $HCO_3^- + Cl^-$. No clinical signs of alkalosis developed. The endogenous creatinine clearance appears to be a far better index of renal function than the direct measurement of any of the non-protein nitrogen components of the blood.

APPENDIX

I. Water liberated by the combustion of fat, protein, and carbohydrate:[110]

1 gm. fat	1.077 cc. water
1 gm. protein	0.396 cc. water
1 gm. carbohydrate	0.556 cc. water

II. Formula for calculating serum sodium from serum bicarbonate and chloride[46] and factors for converting mgm. and volume per cent to milliequivalents.

$Cl^- + 23.2 + (0.5\ HCO_3^-) = Na$, all expressed in meq./1 Convert serum Cl^- expressed as mg. per cent NaCl to meq./1 of Cl as follows:

$$\frac{\text{mg. \% NaCl}}{5.85} = Cl^- \text{ meq./1}$$

Convert *serum* or *plasma* CO_2 capacity or combining power in volumes per cent as follows:

$$\frac{\text{vol. \% } CO_2}{2.3} = HCO_3^- \text{ meq./1}$$

III. Fluids for parenteral use

A. Hypertonic fluids for electrolyte *replacement* for intravenous use only; must be given slowly, preferably by drip. (See D. 2, following, for statements applying to hypertonic solutions.)

1. NaCl solution, 3 to 6 per cent, usually given in amounts of 100 to 200 cc. (100 cc. 6% = 100 meq. of sodium).
2. One molar sodium lactate usually given in amounts of 100 to 200 cc. (166 cc. 1 molar sodium lactate provides the amount of sodium in 1 liter of 1/6 sodium lactate, while 1,000 cc. of 1 molar sodium lactate provides 1,000 meq. of sodium, equivalent to 58.5 gm. NaCl).

B. Solutions used for potassium *replacement*

1. From Govan and Darrow[44]

KCl	2 gm.
NaCl	3 gm.
1 M. Na lactate	40 cc.
Water	710 cc.
Total	750 cc.

This is given very slowly intravenously, taking 2 hours in an adult. Danowski et al.[26] gave KCl at the rate of 1 gm. per hour parenterally to diabetics.

2. Tarail and Elkington[121] administered potassium parenterally as K_2HPO_4 and KH_2PO_4 in molar ratio of 3.55 to 1. These potassium salts added to the other intravenous fluids, such as glucose, in concentrations up to 70 meq. per 1 were given slowly at a rate not in excess of 20 meq. per hr.
3. Parenteral potassium therapy must be given slowly to avoid the dire consequences of toxic concentrations. Whenever possible, potassium should be given by mouth in preference to parenterally.

C. Isotonic fluids used for electrolyte *maintenance*

0.9 per cent NaCl solution (normal saline)
1/6 molar sodium lactate
May be given intravenously, intramuscularly, or subcutaneously.

D. Fluids used for caloric value

May be isotonic or hypertonic with respect to blood cells. Once within the body they diffuse rapidly, diluting electrolytes in both extracellular and intracellular fluid compartments.

1. Five per cent glucose in water
Use intravenously, intramuscularly, or subcutaneously.
2. Ten to 50 per cent glucose
Use intravenously only. If very hypertonic, it should be given slowly by drip. The arm may be be elevated and heated to insure rapid blood flow, thereby lessening the chance of venous thrombosis. Fifteen per cent glucose recommended by Thorn[122] and others can be exceeded in concentration since renal spillage does not occur in anuria.

IV. Recommended non-absorbable enemas

A. Mineral oil or vegetable oil retention enema
B. Magnesium sulfate ..... 30 gm.
Glycerin ..... 60 cc.
Water q.s. ad ..... 150 cc.

V. Recommended daily vitamin therapy

Synthetic vitamin K	1–2 mg.
B_1 (thiamine)	10 mg.
B_2 (riboflavin)	5 mg.
Nicotinic acid	100 mg.
Ascorbic acid	200 mg.

VI. Recommended special diet

High carbohydrate, low protein, fat, potassium, and sodium diet. Both fluid and sodium are kept low (since sodium is controlled by fluid administration). Protein and fat are kept as low as palatability permits. Slowly available carbohydrate is given in large amounts, whereas quickly available carbohydrate is kept low to avoid gastrointestinal irritation and possible vomiting. The diet contains approximately 1,400 calories which should maintain the average normal subject's weight at bed rest. Gas-forming fruits and vegetables are avoided because of the discomfort or nausea they may cause. The nature of the diet is regular rather than soft or bland, since it has been found that patients who tend to be nauseated often prefer the "natural" kinds of food.

SPECIAL DIET

Food	Grams	Protein	Fat	Carbohydrate	Mg. K	Mg. Na.
Breakfast:						
White bread	30	3	—	16	32	201
Farina (30 gm. dry) cooked	200	3	—	21	36	33
Butter	20	—	16	—	2	196
Cream	30	1	6	1	18	12
Sugar	10	—	—	10	—	—
Sliced oranges or grapefruit	100	1	—	10	181	—
Dinner:						
Choice of:						
Asparagus (canned)	100	1	—	5	130	400
Tomatoes (canned)						
Green beans (canned)						
Beets (canned)						
Peas (canned)						
Rice (no salt)	100	1	—	20	22	—
Lettuce	40	—	—	3	124	2
Mayonnaise	10	—	8	—	2	60
White bread	20	2	—	11	22	134
Butter	15	—	12	—	2	147
Choice of:						
Applesauce	100	1	—	20	55	2
Peaches (canned)						
Blueberries (fresh or canned)						
Supper:						
Choice of:						
Peas (fresh)	100	1	—	10	284	5
Winter squash (fresh)						
Tomatoes (raw)						
String beans (fresh)						
Macaroni (no salt)	100	1	—	20	60	1
White bread	20	2	—	11	22	134
Butter	20	—	16	—	2	196
Choice of:						
Pears (canned)	100	1	—	20	129	8
Apricots (canned)						
Strawberries (fresh)						
Huckleberries (fresh)						
Choice of:						
Pineapple (canned)	100	1	—	20	214	1
Plums (canned)						
Raspberries (fresh)						
Loganberries (fresh)						
	—	19	58	198	1.34	1.43

Calories 1,390

No added salt (it is controlled through medication). Fluid is added as requirements demand.

VII. Estimation of blood volume changes

$$\text{Blood volume}_1 = \frac{CV}{Hct_1}$$

Assuming a constant CV then

$$\text{Blood volume}_2 = \frac{CV}{Hct_2}$$

Where CV is the absolute or total cell volume whose magnitude is either measured or assumed.

Where Hct_1 is the initially determined hematocrit.

Blood volumes 1 and 2 are initial 1 and final 2.

See reference 41 for estimation of total cell volume.

ACKNOWLEDGEMENT

We are grateful to Dr. Kenneth Scott of the X-ray Division for making available facilities for measurements with Na_{24}, to Dr. Frank Hinman, Jr., of the Urological Division for permission to publish the data in the case reported, and to Miss Virginia Stokdyke of the Dietary Department for preparation of the diet.

The following references were used for Tables 1 and 2, Part I: 4, 5, 6, 7, 11, 12, 16, 17, 18, 19, 21, 27, 30, 31, 33, 35-37, 47, 50, 54, 56, 57, 59, 63, 66, 68, 69, 70-72, 74, 80, 82, 85, 87, 88, 92, 97, 102, 105, 114, 116, 120, 121, 126, 129, 130, 146-149.

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CASE REPORTS

Allergic Sinusitis Treated as a Deficiency Disease

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ALTHOUGH sensitivity to allergens is of course the immediate cause of allergic rhinitis and allergic sinusitis, the sensitivity itself may be but a symptom of chemical imbalance arising from dietary deficiency.[1]

It is felt that too often the treatment of allergic disease is directed at superficial desensitization or to avoidance of contact with allergenic agents, and that not enough consideration is given to the discovery and reversal of more abstruse underlying conditions which might account for the sensitivity. For this reason, in the treatment of a patient with allergic disturbance of the nasal passage or sinuses, careful study should be made of the dietary intake over an extended period, with special attention to deficiencies in minerals and nutrients such as vitamins and proteins.

In this regard, the author has previously reported several cases[1] in which patients with frequent colds and sinusitis were considerably improved following courses of prescribed diets supplemented with extra vitamins in large quantity to overcome deficiencies which had been discovered.

The following two additional case reports are pertinent:

CASE 1: The patient, a male, 54 years of age when first observed in April 1948, had had intermittent attacks of sinusitis since 1917. In 1925 an operation had been done for correction of deviation of a septum. Following a severe attack of sinusitis in 1945, with nasal discharge in large quantity, tests for allergic reaction were carried out, and the patient was found to be sensitive to a number of pollens and foods as well as to dust and mold. A diet to eliminate the food allergens was prescribed and injections of the indicated antigens were given twice a week. The injections were still being given when the patient consulted the author in 1948.

The patient was undernourished as indicated by the fact that he was 71½ inches tall and weighed only 142 pounds. Examination of the nose showed edema of the mucous membrane and excessive secretion, interpreted as evidence of allergic rhinitis.

X-ray studies showed density in both antra but no evidence of bone destruction.

Upon examination of the blood, erythrocytes were found to number 4,900,000 with a hemoglobin value of 75 per cent; leukocytes numbered 10,000 with a normal distribution. The cholesterol content of the blood was 326 mg. per 100 cc. Numerous pus cells and many Gram-positive cocci arranged in groups and chains were noted in examination of a smear of nasal secretion.

The patient was referred for a dietary survey and the report was that the diet appeared to be adequate despite the elimination of supposed allergens. (It should be noted, however, that the appraisal of the diet was made on the basis of information elicited from the patient, and it was not learned until some time later that, in replying to questions, the patient had considered only the diet he then was following, which had been prescribed. Hence the survey inadvertently did not take into account the long-time eating habits of the patient.)

In view of the fact that nasal discharge did not abate and the patient was underweight, additional nutrients and vitamins were prescribed despite the favorable dietary report. Vitamin A (150,000 units), vitamin C (750 mg.) and three vitamin tablets* were given daily for one week. As the patient still had constant stuffiness in the nose at the end of that time, 300 mg. of nicotinic acid was added to the daily dosage. In two days the nose was entirely open and the amount of discharge was greatly reduced. The dosage was continued for the next two months and the improved status of the patient was maintained. At this time the dosage was cut to one-third the former level and nasal discharge increased within the next five days. When the previous dosage schedule was resumed, improvement again followed and was maintained for several months. Subsequently when an acute flare-up occurred, it was learned that shortly before this attack the patient had neglected to take the nicotinic acid and had eaten a dozen pieces of chocolate, to which he was known to have allergic sensitivity.

It was reported that the left antrum was found to contain foul-smelling pus. After repeated lavage with instillation of penicillin and micro-crystals of sulfathiazole, and penicillin systemically, the amount of discharge decreased. When the penicillin given systemically was stopped and the frequency of lavage was reduced, pus formation recurred. A Caldwell-Luc operation was done. The antrum was full of pus and polypoid mucous membrane. The membrane was entirely removed and an opening was made in the inferior meatus of the nose. Three days later the discharge had almost entirely subsided.

Nine months later there had been no recurrence of heavy discharge.

COMMENT

From the outset of treatment in this case it was hoped that supplying needed nutrients in large quantity might abate the severe sinusitis and obviate operation. In this regard the improvement following the giving of supplemental vitamins and nicotinic acid in large quantity was encouraging. As operation at last was necessary, however, it is probable that it would have been better to have opened the antrum earlier. A possibility to be considered, however, is that conservative treatment might have availed had the pathologic change not been so firmly established.

CASE 2:† When first observed the patient, a woman 63 years of age, had been taking Theominal® (luminal and theobromine), three tablets daily in divided doses, which had

*Each tablet contained: Thiamine chloride, 3 mg.; riboflavin, 5 mg.; pyridoxine, 1 mg.; pantothenic acid, 10 mg.; nicotinic acid, 10 mg.; choline, 30 mg.; inositol, 30 mg.; dry yeast powder, 240 mg.

†Case reported to the author by David Boody, M.D.

been prescribed by a physician a month previously because of blood pressure of 240 mm. of mercury systolic and 150 mm. diastolic with complaint of headache, dyspnea, orthopnea, palpitation and nocturia.

The patient said she had had "hay fever" intermittently over a 15-year period and that attacks were initiated by change of temperature and exposure to pollens and dust but were not caused by change of seasons or foods. Episodes were characterized by profuse watery nasal discharge, sneezing, stuffy nose and mild dyspnea. Attacks occurred twice or thrice weekly and lasted two or three days. Tonsillectomy and submucous resection had been done ten years previously. Local treatment of various kinds had given temporary relief. Dyspnea and palpitation had subsided, the patient said, since she had begun to take Theominal.

Upon examination the nasal membranes were found to be pearly gray and boggy. Bilateral edema of the middle turbinate was noted. There was seromucoid discharge and postnasal drip with mild posterior pharyngitis.

The heart was enlarged to the anterior axillary line and pounding tones were noted. The blood pressure was 230 mm. of mercury systolic and 140 mm. diastolic. Results of laboratory analyses were normal except for eosinophilia (4 per cent) and a trace of albumin in the urine.

Analysis of the patient's diet showed it to be low in (1) vitamins A, D, and E, (2) B complex, (3) ascorbic acid and (4) calcium and phosphorus. The patient had voluntarily restricted salt intake for several years.

The diet was revised to include proper nutrients and vitamins, and the restriction on salt intake was kept in force. Three vitamin tablets,* three capsules‡ containing vitamin A with tocopherol acetates, and 300 mg. of ascorbic acid, in divided daily doses, were prescribed. Theominal was continued.

Gradual improvement followed. At the end of six months, episodes of rhinitis occurred only about once a month and were considerably milder (only one handkerchief a day was needed, as against 15 previously). The nose and throat were normal in appearance. The blood pressure was stabilized at 180 mm. of mercury systolic and 90 mm. diastolic, but the heart was still enlarged and the pounding tones still present.

SUMMARY

In one of the two cases reported, the patient had allergic sinusitis of long standing. Dietary deficiencies were discovered. Although operation finally was done, the nasal discharge had decreased greatly following ingestion of additional nutrients and vitamins in large quantity over a period of several weeks, and relapse occurred when the dosage was reduced.

In the other case, the patient had a history of hay fever of 15 years' duration. She was taking luminal and theobromine because of blood pressure of 240 mm. of mercury systolic and 150 mm. diastolic. Upon dietary analysis, deficiencies were noted and the diet was revised to include proper nutrients and vitamins. Luminal and theobromine were continued. Rhinitis was greatly relieved and the blood pressure at the end of six months was stabilized at 180 mm. systolic and 90 diastolic.

1000 California Street.

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‡Each capsule contained 50,000 units of vitamin A and 36.8 mg. of d-alpha tocopherol acetate.

Barnyard Fowl as a Source of Human Ornithosis

Case Report

H. KARRER, M.D., B. EDDIE, Dr.P.H., and R. SCHMID, M.D., *San Francisco*

ALTHOUGH psittacosis in man is most commonly attributed to birds of the psittacine family, many cases have resulted from contact with non-psittacine birds, particularly pigeons,[1, 4] fulmar petrels and ducks. Less than 50 per cent of the clinical infections in the United States from January 1945 to November 1947 were attributable to birds of the parrot family (Table 1). During this same period, the virus was isolated in many instances from birds other than parakeets or pigeons by Eddie (Table 2). It has been known for several years that chickens can carry a psittacosis-like virus but very few cases have been reported. Meyer and Eddie[4] described a human infection in which chickens were the probable infective source. In 1947, they encountered another case in which ornithosis was diagnosed on the basis of typical clinical symptoms and the complement-fixation test (titer: 1:16++++) and the isolation of the virus from chickens on the patient's farm. Because intensive penicillin therapy was instituted immediately after diagnosis, attempts to isolate the virus from the patient's blood and sputum were not made.

The case presented in this paper can be considered as another example of clinical ornithosis acquired from chickens. The extreme rarity of such cases justifies a detailed description.

CASE REPORT

The patient,* a 49-year-old chicken farmer, was admitted to the University of California Hospital on February 11, 1949. He had complained of fatigue and general malaise since about December 4, 1948, when herpes developed on the upper lip and nose. In spite of these mild symptoms, he continued to work until January 30, 1949. At this time he had several chills, his temperature was consistently elevated to 101°F. to 103°F. for several days and this fever was accompanied by severe cervico-occipital aching. These symptoms were relieved by aspirin. The patient had no chest pain, dyspnea or sore throat, but he did have a slightly productive cough with a little yellowish green sputum. He had lost about 30 pounds in the previous ten weeks.

On admission to the hospital on the twelfth day after the onset of chills and fever, he did not appear to be particularly ill. Physical and laboratory examination revealed the following:

The temperature was 37.9°C., pulse rate 90 beats per minute and respiratory rate 18 per minute. The blood pressure was 135 mm. of mercury systolic and 95 mm. diastolic in the supine position and 90 mm. systolic and 60 mm. diastolic in the standing position. Neurologic and cardiac examination revealed no abnormalities. Aside from fine rales over the base of the right lung heard anteriorly and posteriorly, and a slight decrease in breath sounds, pulmonary signs were not remarkable. The thoracic roentgenogram, first reported to give no evidence of disease, on review revealed a very fine homogeneous infiltration of the right lung.

The concentration of hemoglobin was 15.3 gm. per 100 cc. of blood; the hematocrit reading was 44. The leukocyte count was 10,100 per cubic millimeter of blood and the differential count was: polymorphonuclear leukocytes, 52 per cent (48 per cent filamentous, 4 per cent nonfilamentous); eosinophils,

*Case reported with permission of his physician, Dr. H. D. Brainerd, assistant clinical professor of medicine and pediatrics, University of California Medical School.

From the George Williams Hooper Foundation (Karrer and Eddie), and the University of California Hospital (Schmid).

TABLE 1.—*Psittacosis in Birds Other Than Parakeets and Pigeons January 1945 to November 1947*

Bird	Location	Virus Isolation: Tested	Virus Isolation: Positive	Remarks
Ducks	Long Island, New York	97	35	
Chickens	Oakland, California	19	4	Pigeon exposure. Virus isolated from viscera and intestines.
	New York	4	3	Pigeon exposure. Virus isolated from intestines.
	Pasadena, California	2	2	Virus isolated from viscera and intestines.
Sea gulls	East and West Coast	5	3	American herring gull.
Dove	New York	1	1	
House finch	California	1	1	Linnet (Carpodacus Mexicanus)
Totals		129	49	

2 per cent; lymphocytes, 28 per cent; monocytes, 18 per cent. Platelets were normal. The sedimentation rate was 35 mm. in one hour (Westergren), corrected 28. Cold agglutinins were not found and agglutination tests for typhoid, paratyphoid A and B, tularemia and brucellosis were negative. Routine blood cultures were also negative.

The first serum specimen was taken February 12 (13th day after onset of chills and fever). The complement-fixation reaction with psittacosis antigen was positive in dilutions of up to 1:32++++ and 1:64++. In the presence of Q fever antigen, the complement-fixation test was negative. The same blood sample was used for mouse inoculation and a psittacosis-like virus was recovered with considerable difficulty, denoting the low pathogenicity of the organism. Attempts to isolate the virus from the sputum failed. A second serum sample was taken on February 17. Complement-fixation test was positive in the presence of psittacosis antigen in dilutions up to 1:32++++ and in the presence of lymphogranuloma venereum antigen (Lygranum®) was positive in dilutions up to only 1:16++.

The course of the illness as observed in the hospital was benign. The patient was almost afebrile when he entered (temperature: 37.9°C.) and he had no complaints. He did not receive specific treatment. After two days of hospitalization he became afebrile and remained so. He was discharged on February 17 (7th day of hospitalization). It was suggested that he take epinephrine because of slight postural hypotension.

An epidemiologic survey was begun on March 18. The patient's small farm home, inhabited by the patient and his wife, was located in Castro Valley, California. At the time of the investigation he had about 500 laying hens which were kept in a closed wooden barn. The hens looked quite healthy and the owner did not complain of unusual loss or egg-production drop in the past. He had had them for about one year and new birds had not been introduced into the flock. The door of the barn was kept closed and there were no broken windows or major defects in walls or roof; therefore, it seemed impossible that wild doves or pigeons (known to be carriers of the ornithosis virus) could have entered the room. Although there was a pigeon loft in the neighborhood, the patient had never been closer than 300 feet from it, nor could he remember ever having had contact with parrots or parakeets or any other birds. The hens were kept in steel wire cages which formed long files through the whole length of the room. Accordingly, there was ample possibility of contact between birds of neighboring cages, since the wire netting had quite large openings. The chicken droppings fell down through an egg-catching wire net and accumulated on the floor; from time to time they were cleaned off. The patient did not remember having made a thorough cleaning immediately preceding the onset of illness.

TABLE 2.—*Sources of Human Psittacosis in the United States—January 1940 to November 1947*

	Cases				
	1945 - Nov. 1947				Total 1940-
Exposure to	1945	1946	Nov. 1947	Total	Nov. 1947
Psittacine birds	35	13	15	63	130
Pigeons	33	12	9	54	106
Other birds or several kinds of birds	8	10	7	25	40
Ducks	3		1	4	
Canaries	2	2		4	
Grouse	2			2	
Pheasant	1			1	
Chickens			2	2	
Linnet			1	1	
Pet shop		1		1	
Infected laboratory material	3	4		7	7
Unknown source	1	5	3	9	13
Totals	80	44	34	158	296

TABLE 3.—*Serologic Study of Chickens on Patient's Farm: Complement-fixation Inhibition Test*

	Titers* Serum Dilutions				
Chicken	1:2	1:4	1:8	1:16	1:32
1	—	—	±	+	++
2	—	—	±	+	+++
3	—	—	+	++	+++
4	—	+	++	+++	+++
5 & 6	±	±	+	+	++
7	±	+	++	+++	+++
8-10	+	++	+++	+++	+++
11	++	++	+++	+++	+++
12-15	+++	+++	+++	+++	+++
16 & 17	++±	++±	++±	++±	++±
18	++++	++±	++±	+++	+++
19	++++	++±	++±	++±	++±
20	++++	++++	++++	+++	+++

Fixation control: +++

Complement-fixation test: Negative in all instances.

*++± = between +++ and ++++

Blood samples were taken from ten white Leghorns and ten New Hampshire reds (4 per cent of the flock). These birds occupied ten cages which were apart from each other. They were considered to comprise an adequately representative group for the survey. The clotting time for the blood from ten chickens was extremely long; some samples did

not clot for as long as two or three hours. The 20 serum specimens were tested by the complement-fixation inhibition method (Karrer and co-workers). The results are recorded in Table 3. The serum of ten birds gave a positive reaction, that of one, a questionable reaction, and of nine, a negative reaction. Four of the birds with positive reactions were white Leghorns, six were New Hampshire reds.

During the second visit, on April 13, the laying charts attached to each chicken cage were inspected. Egg production of the seropositive birds did not differ strikingly from that of the seronegative ones. In fact, some of the birds with positive serum reactions were better layers than others with negative reactions.

At this time a blood sample was taken from the patient's wife. The serum fixed complement in the presence of psittacosis antigen in a serum dilution of 1:2++++; this is considered to be an insignificant nonspecific titer. Lygranum® and Q fever antigens gave no fixation. So far as the patient knew, none of his neighbors had had an illness similar to that he had had.

DISCUSSION AND CONCLUSIONS

In the presented case it was possible to isolate the virus from the patient himself, but it could not be isolated from the spleen, liver, kidneys or cloaca of two tested chickens. The patient's positive serologic findings were not conclusive since a rise in titer during hospitalization was not demonstrated; it may have occurred early in his illness before the first specimen was tested or during the constant exposure to infected chickens. This case illustrates again the desirability of having several samples so that comparisons may be made. Isolation of the virus from the blood stream conclusively proves that the patient did have an active ornithotic infection. There seems to be little doubt about the infective source. So far as could be determined, the patient had had no contact with any birds except his chickens. Positive evidence of ornithotic infection was found among ten of twenty tested birds. The ultimate origin of the infection in the flock remains obscure. The patient usually did not kill the birds, but sold them alive as soon as their egg production became unsatisfactory; therefore the danger of acquiring the infection by the direct handling of organs (especially kidneys, liver and spleen) did not exist. But exposure to feces on the floor and the daily handling of the eggs which had passed through virus-contaminated cloacas, as well as the daily exposure to dust from the chicken house, offered ample opportunities of infection. Moreover, the closed barn was likely to retain all dust material in much higher concentration than the usual half-open chicken houses. Since the virus remains viable in the dried state for many weeks it can accumulate considerably under such conditions. The patient had not, preceding the onset of illness, performed any unusual clean-up in his barn which would have increased the dry dust contaminated with fecal, virus-containing material. Neither did he have any sick birds, which in other instances have been found to be especially infective for man.[3]

The illness was mild, in contrast to that caused by infections due to exposure to sick pigeons and parakeets. This fact perhaps allows the conclusion that the infection had not been massive, although it is possible that the chicken virus is of specifically low infectiousness. The difficulty with which the virus was recovered from chicken organs by mouse passages speaks in favor of the low infectiousness of the organism in this instance, although it is quite high for chickens, and in favor of low pathogenicity. It is possible that in other instances the human host might provide better conditions and the infection might become severe, or that another strain of the same origin might be more destructive. It was fortunate that in the reported case epidemiological investigations could be carried out. Evidence to the present indicates that chickens are a rare source of clinical infections in man. The mildness and the absence of characterizing symptoms of the condition indicate that the disease could easily run its course without diagnosis. The large number of chickens in many populated areas undoubtedly creates many opportunities for contact. It seems possible that awareness of the disease might lead to epidemiologic surveys and that these in turn might reveal that the infection is not uncommon. While, as it is now known, it is not significant among acute infections, the protracted subacute form is apparently costly from the standpoint of the patient's well-being and hence is of some diagnostic importance. Should more careful diagnostic investigation reveal that the infection is prevalent and in some instances severe, the therapeutic aspect would gain importance. Early diagnosis would give the patient the benefit of effective antibiotic therapy (penicillin in high dosage, possibly aureomycin). The infection index in man is probably low, and a predisposition may be required in order to allow development of pronounced clinical manifestation of the disease. In cases in which there is suspicion of ornithosis acquired from chickens, the birds can easily be tested by the complement-fixation inhibition method, which is not much more elaborate than the complement-fixation test, and the patient by repeated complement-fixation tests.

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California MEDICINE

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450 SUTTER, SAN FRANCISCO 8 PHONE DOUGLAS 2-0062

EDITORIALS

1950 Annual Session

On May 3, 1950, the California Medical Association rang down the curtain on its Annual Session, held in San Diego for the first time in ten years. Despite the difficulties attendant on holding scientific sessions in San Diego and House of Delegates meetings on Coronado Island, the meeting attracted a large registration and proceeded with dispatch, albeit with minor irritations.

Scientific sessions catered to good attendance and produced many stimulating papers. Section and general meeting arrangements brought all scientific meetings together in two adjoining buildings in famed Balboa Park, with registration and exhibit facilities in the same location. Selected papers from those meetings will appear in CALIFORNIA MEDICINE in this and coming issues.

On the business side, the House of Delegates held its meetings in Hotel del Coronado, scene of many vigorous meetings of the Association in 1940 and earlier years. The two sessions of the House were well attended and lasted into the small morning hours before final agreement came on several contested issues.

Among other items passed upon by the House of Delegates were (1) resolutions urging cooperation by hospitals in preventing corporate practice of medicine by the hospitals, (2) resolutions calling upon the officers, employees and Delegates of the Association to subscribe to an anti-Communist oath as a prerequisite to holding office, employment or a Delegate's seat, and (3) a report advocating the discontinuance of the present radio program at the close of the year, in favor of a "grass-roots" approach to the broad problem of public relations.

The resolutions on hospitals appear in the printed resolutions appearing elsewhere in this issue and are self-explanatory. They ask cooperation in curtailing certain medical practices in which some hospitals indulge as a matter of business, and are in line with earlier decisions of the Association and of the American Medical Association.

The anti-Communist declaration required of officers, employees and Delegates was adopted in the form of two amendments to the by-laws. In essence the declaration states that the physician or employee is not and has not been a member of any organization advocating the overthrow or change in the form of government of the United States by force or by unlawful means. As in other similar instances recently publicized, criticism has been leveled at this declaration on grounds that it violates personal principles, is ineffective and is the cause of harmful dissension and controversy. However, the by-law amendments were adopted by the House of Delegates and today constitute the regulations under which officers, employees and Delegates may serve in their respective capacities. All present officers and employees have subscribed to the declaration and members of the House of Delegates will be required to do so before being seated at the next meeting of the House.

Public relations for the profession at the grass-roots level was one of the most-discussed topics at the meeting. Through the Auditing Committee, the Council of the Association proposed that a down-to-earth approach be made on all matters affecting the public response to the activities of physicians in their individual practices. This new approach to the problem—new to the C.M.A. at least—follows the successful experience of several county medical societies in getting at the root of the public relations of the profession through analyzing the public relations of their individual members and taking steps to augment the favorable factors and correct the

unfavorable ones. Under the program adopted by the House of Delegates the Association will undertake to develop a program designed for the utilization of the individual members and carry this program into the county medical societies through official visits by the top officers of the Association. Further announcements on this campaign will be made as plans attain greater maturity.

All members are urged to read and study the deliberations and decisions of the House of Delegates. This body is the representative law-making body of the Association, representing the membership as a whole, and its actions are binding on members, officers, and Councilors alike. The brief time needed to review the transcript of its sessions will constitute a worthwhile investment.

C.M.A. Special Session

Plans have been made for a special session of the House of Delegates of the California Medical Association. The meeting will be held in Sacramento on December 2 and 3, 1950, together with simultaneous meetings of the Administrative Members of California Physicians' Service.

This meeting presages similar sessions to come. The proposed Constitution and By-laws of the Association, now lying on the table, contemplate the holding of two meetings annually of the House of Delegates; if these documents are adopted, the county medical society representatives may look forward to semi-annual meetings as a means of keeping the business of the Association up to date.

In years past the C.M.A. has had occasion several times to call special meetings of the House of Delegates. The last two such gatherings, in 1935 and 1945, were both called for the purpose of giving special attention to matters of health insurance, the 1945 session being directed at the proposals of Governor Earl Warren for compulsory health insurance legislation. Both meetings have attracted a full attendance and both have accomplished, in a short period of time, much more in the way of tangible results than the Delegates have been accustomed to in the annual sessions, where scientific gatherings and other events have tended to divert at least a part of the Delegates' attention.

Full details of the Special Session, along with the agenda, will be announced at a later date. Meanwhile, please mark the dates on your calendar. The business of the Association requires this meeting, and similar ones to come, and all Delegates should plan to be present and participate in the concentrated discussions which will be scheduled.

Letters to the Editor . . .

Scientists Have to Read Scientific Writing

Easy writing's curst hard reading—
SHERIDAN

Advances in science are founded on what is already known. Scientists telling other scientists what advances they have made should presume a reasonable acquaintance with what is already known. The competition for readers' attention is so sharp that any one writer's quota is mighty small. He would do well to use what readers' attention he can get for just one purpose, namely: to get his message across. He will see that it is a short-sighted policy to use up any of his readers' attention for retelling what is already known. Yet we see many an essay, the first half of which is devoted to historical background and other scientists' false starts.

We were all medical students once, when we learned that success depended on convincing professors that we knew something. We were all struggling young practitioners once, and believed (rightly) that success depended on convincing our patients and our colleagues that we had a solid scientific foundation for our art. But when we undertake to write and talk, as clinical scientists, for the eyes and ears of other clinical scientists, we should show ourselves mature enough to refrain from the exhibition of knowledge for the sake of its exhibition.

Let us therefore exhort our essayists to write sharply to the point. Let them design their structure with no waste floor space, dig to bedrock only under the rooms that carry weight, and buy no stone lions for the front stoop.

Those who write for CALIFORNIA MEDICINE can hope for 10,000 readers. Is it not simple economics to say: The essayist can well afford to spend 20 hours shortening and sharpening his presentation if his readers save a sum total of twice that time in reading it. Forty hours among 10,000 readers amounts to only 15 seconds each. Can one not by taking thought subtract a minute from the reading time?

Moreover, if the essay is short and full of graphic presentation, reader willingness will be correspondingly high. That is to say, if the thing looks half as long to read, four times as many men will read it. And after all, that's what you're after, isn't it, to get your ideas into the minds of your fellows? The figures are purely intuitional, but let every ambitious essayist submit them to his own intuition and see if he is not in at least "qualitative" agreement.

R. R. NEWELL, M.D.
Stanford University School of Medicine
Clay and Webster Streets
San Francisco 15, Calif.

CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

A.M.A. President-Elect

John W. Cline is the new President-elect of the American Medical Association. By its action on Thursday, June 29, the House of Delegates of the American Medical Association honored California and San Francisco by electing to its highest office the second Californian to be so honored. In 1923 Dr. Ray Lyman Wilbur became the first Californian to be placed at the helm of the American Medical Association. Like his distinguished and respected predecessor, Dr. Cline in his contributions to American medicine has shown himself to be eminently qualified for the high position to which he was elected.

It is most difficult to properly appraise the value of John Cline's services to California and American medicine. It is impossible to imagine what the position of American medicine would be today had we not had his leadership and counsel.

Born in Sonoma County, California, the son of a practicing physician, he attended public schools in California and received an A.B. degree at the University of California in 1921. His medical training was at Harvard University where he obtained his M.D. in 1925. Following an internship in the Faulkner Hospital, he became house officer at Massachusetts General Hospital in Boston for two years and then resident surgeon at Bellevue Hospital, New York City, in 1927-1929. Since that time he has practiced surgery in San Francisco. Dr. Cline's contributions to the surgical literature have been numerous and his professional attainments have been such as to place him in the top rank of San Francisco surgeons. He is associate clinical professor of surgery at Stanford University School of Medicine, assisting visiting surgeon at San Francisco Hospital, associate surgeon at Children's Hospital, and a member of the board of directors of St. Francis Hospital. His professional attainments have been recognized by a fellowship in the American College of Surgeons, membership in the San Francisco Surgical Society, the Pacific Coast Surgical Association, and other scientific organizations, to all of which he has contributed much of his abilities.

Early in Dr. Cline's career his capacity for leadership was given recognition in his election as student body president at the University of California. His colleagues in the field of medicine have recognized his ability in organizational work and his sound judgment by electing him to the board of directors and later to the presidency of the San Francisco County Medical Society, to membership on the Council of the California Medical Association, and to the presidency of the association during the year 1947. Those who have had the privilege of working with him in the field of organized medicine know well his organizational and executive ability. It has been during the period of his leadership that the California Medical Association has become a well-knit, militant organization able to combat all efforts to promote state medicine over the past few years.

Dr. Cline was elected a delegate from the California Medical Association to the American Medical Association in 1945. His remarkable ability is further reflected in the place of eminence which the California delegation now occupies in the House of

Delegates of the American Medical Association. While he was chairman of the California delegation the process of alerting the American Medical Association to the dangers of government compulsory medicine began. From the first early and feeble attempts to put new life into the Board of Trustees and House of Delegates, to the emergency presented by the unexpected election results of 1948, John Cline has been the moving spirit and the guiding hand which enabled the California delegation to offer to the American Medical Association a tested and effective plan to combat socialized medicine.

His appointment in 1948 as a member of the newly organized Coordinating Committee of the A.M.A. was followed promptly by establishment of the National Education Campaign of the association. On a national scale this campaign has been a most effective one in furthering voluntary health insurance, in improving the public relations of the American Medical Association, and in thwarting those who advocate socialization of medicine.

Because of his statesmanlike conduct as a member of the House of Delegates and of the Coordinating Committee of the American Medical Association he has gained the respect and admiration of these groups as well as of the Board of Trustees. His great and outstanding ability as a leader of American medicine has now been further recognized by the House of Delegates which has honored him by awarding the highest accolade in its power to bestow.

The California delegation loses its highly respected leader, but the American Medical Association has gained a leader who is preeminently fitted to guide the ship of medicine through the stormy course before it. We of California are honored by the selection of John Cline as President-elect of the American Medical Association, and that great organization is to be congratulated on garnering the finest talent of California, or any other state for that matter, for leadership of American medicine.

Council Meeting Minutes

369th Meeting

Tentative Draft: Minutes of the 369th Meeting of the Council, Hotel Del Coronado, Coronado, April 29, 1950.

The meeting was called to order by Chairman Shipman in the Palm Room of Hotel del Coronado, California, at 9:00 a.m., Saturday, April 29, 1950.

Roll Call:

Present were President Kneeshaw, President-elect Cass, Speaker Alesen, Vice-Speaker Charnock, Councilors Ball, Crane, Henderson, Anderson, Ray, Montgomery, Lum, Pollock, Green, Shipman, Bailey, West, MacLean, Frees and Thompson, and Secretary-Treasurer Garland. Absent for cause: Editor Wilbur.

Present by invitation were Dr. Dwight H. Murray, legislative chairman; Dr. John W. Cline, A.M.A. Delegate; executive secretary Hunton, legal counsel Hassard, field secretary Clancy, county society executive secretaries Gillette of Fresno, Young of San Diego; Dr. R. O. Bullis, secretary of the Los Angeles County Medical Association; Mr. Brooks Crabtree, legal counsel for the San Diego County Medical Society; and Messrs. Clem Whitaker, Clem Whitaker, Jr., James Dorais and Ned Burman of public relations counsel.

1. *Minutes for Approval:*

(a) On motion duly made and seconded, minutes of the 368th meeting of the Council, held March 19, 1950, were approved.

(b) On motion duly made and seconded, minutes of the 220th meeting of the Executive Committee, held March 19, 1950, were approved.

2. *Membership:*

(a) A report of membership as of April 22, 1950, showing 9,914 dues-paid members, was received and ordered filed.

(b) On motion duly made and seconded, one member whose 1949 and 1950 dues had been paid since the last Council meeting was voted reinstatemen as an active member.

(c) On motion duly made and seconded, 1,225 members whose 1950 dues had been received since April 1, 1950, were voted reinstatement as active members.

(d) On motions duly made and seconded in each instance, six applicants were elected as Associate members. These were:

Bruno Gerstl, Alameda County.
Wenonah King Thom, Butte-Glenn County.
Walter Rohlfing, Jr., Fresno County.
Mildred Van Cleve, Riverside County.
H. D. Rose, San Joaquin County.
Helen B. Hart, Santa Barbara County.

(e) On motions duly made and seconded in each instance, two applicants were elected to Life Membership. These were:

Jesse W. Citron, Alameda County.
H. B. Osborn, Ventura County.

(f) On motions duly made and seconded in each instance, five applicants were elected to Retired Membership. These were:

Richard E. Brenneman, Calvin B. Witter, Los Angeles County.
James A. Cutting, Santa Clara County.
J. B. Blackshaw, A. A. Thurlow, Sonoma County.

(g) On motions duly made and seconded in each instance, reductions in dues were granted to 14 members because of illness or postgraduate studies.

3. *Financial:*

(a) A report of bank balances as of April 22, 1950, was received and ordered filed.

(b) The executive secretary reported that New Mexico Physicians' Service had repaid an additional $1,000 on its loan from the association and that further repayments had been promised on the basis of new sources of income developed by N.M.P.S.

(c) The executive secretary reported that $1,883.82 of the $10,000 total fund of the San Diego voluntary health insurance program had been returned as the unused balance of the fund. Of the amount returned, one-half was credited to the association and the other half to the other participating organizations.

4. *Auditing Committee:*

Chairman MacLean of the Auditing Committee read the report of the committee on its study of proposed public relations activities. The report recommended the establishment of a public relations department within the association and the discontinuance of the radio program in favor of alternate activities. On the basis of its recommendations the committee suggested that dues for 1951 be established at $36 per active member.

Dr. John W. Cline and Mr. Clem Whitaker discussed these recommendations and there was general discussion.

It was moved and seconded that the report as a whole be tabled but that the major portions of it be considered individually. The motion did not come before the Council for a vote but an informal poll showed that (1) the radio program should be continued; (2) that dues be retained at $45 and (3) that local public relations programs should be strengthened under association sponsorship. The Auditing Committee was requested to revise its report accordingly and report back to the next meeting.

5. *Legal Department:*

Mr. Hassard reported that a proposal had been made by certain hospital interests to institute court action to secure an interpretation of state laws relating to the qualifications for members of staffs of hospitals organized under the District Hospital Law. On motion duly made and seconded, it was voted that the association not sponsor or advocate such proposed litigation.

6. *Award for Journalism:*

Dr. Ray reported that the Santa Clara County Medical Society had established an annual award for journalism for stories or series of stories in newspapers generally circulated in the Santa Clara County area which were adjudged beneficial to the public in matters of health or medical care. The recipient of the first annual award had been selected and Dr. Ray asked that the agenda of the House of Delegates be amended to permit the award to be made before that body. It was regularly moved, seconded and voted to make this change in the agenda of the House of Delegates.

7. *1949 House of Delegates Resolution:*

Discussion was held on a resolution adopted by the 1949 House of Delegates on which inadvertently no action had been taken during the year. It was agreed to recommend to the 1950 House of Delegates that a committee be appointed to act during the coming year on possible administrative procedures in California Physicians' Service.

8. *San Diego County Disaster Fund:*

Dr. West asked authority for the San Diego Disaster Fund to solicit funds during the Annual Session for the benevolences administered by the organization. On motion regularly made and seconded, such authority was granted.

9. *Blood Bank Commission*

Dr. Richard O. Bullis, secretary of the Los Angeles County Medical Association, was asked about the attitude of the council of that association toward the proposed establishment of a revolving loan fund of $150,000 to be used, with matching funds, for establishing blood banks in several areas of California. He reported that, for reasons of local policy, the county association was working toward an agreement with the American National Red Cross for a cooperative working agreement which would in no way conflict with the plans of the association's Blood Bank Commission. In regard to the proposed loan fund, he expressed his belief that the trustees of the Los Angeles County Medical Association would approve the establishment of such a fund and its use in inaugurating blood banks in the outlying areas of Los Angeles County. After discussion, it was agreed to add to the Council's report to the House of Delegates the proposal that such a fund be established.

Adjournment:

At this time, 11:50 a.m., the Council adjourned until 7:30 a.m., Sunday, April 30, 1950.

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370th Meeting

Tentative Draft: Minutes of the 370th Meeting of the Council, Patio Dining Room, Hotel del Coronado, Sunday, April 30, 1950.

The meeting was called to order by Chairman Shipman at 7:30 a.m., Sunday, April 30, 1950, in the Patio Dining Room, Hotel del Coronado, Coronado, California.

Roll Call:

Present were President Kneeshaw, President-elect Cass, Speaker Alesen, Vice-speaker Charnock, Councilors Ball, Crane, Henderson, Anderson, Ray, Montgomery, Lum, Pollock, Green, Shipman, Bailey, West, MacLean, Frees and Thompson, and Secretary-Treasurer Garland. Absent for cause: Editor Wilbur.

Present by invitation were Dr. Dwight H. Mur-

ray, legislative chairman, executive secretary Hunton; field secretary Clancy, legal counsel Hassard, county society executive secretaries Gillette of Fresno, Tobitt of Orange, Young of San Diego, Wood of San Mateo, and Donovan of Santa Clara, and Messrs. Clem Whitaker, Clem Whitaker, Jr., James Dorais and Ned Burman of public relations counsel.

1. *Industrial Accident Medical Fees:*

Announcement was made of a meeting scheduled for noon, April 30, of the Committee on Industrial Accident Fees, at which time matters relating to industrial fees would be open for discussion.

2. *Auditing Committee Report—Budget for 1950-1951:*

Dr. MacLean, chairman of the Auditing Committee, read the revised report of the committee, which recommended a public relations budget item of $150,000 for the 1950-1951 fiscal year and recommended dues for the 1951 calendar year at $40 per active member. On motion duly made and seconded, the proposed budget and dues were approved by the Council for presentation to the House of Delegates.

3. *Legal Department:*

Mr. Hassard reported on new automobile emblems being sold by a California manufacturer and pointed out that such emblems were useful only in meeting one section of the motor vehicle laws and were not intended to replace standard emblems in use by physicians, particularly the emblem issued by the American Medical Association.

4. *Executive Session:*

At this point the Council went into executive session, rising therefrom prior to consideration of the next item of business.

5. *Organization Expense:*

On motion duly made and seconded, it was voted to appropriate $10,000 as additional funds to meet organization expenses in San Diego County.

6. *Proposed New County Society Charter:*

Dr. Lum reported that the Contra Costa County Medical Society wished to combine with the Alameda County Medical Association to form the Alameda-Contra Costa County Medical Association. This move has been approved by the councils of both county societies and by the membership of the Contra Costa Society by a vote of 90 to 14. The membership of the Alameda County Medical Association will be asked to approve the merger as a prerequisite to the issuance of a new charter.

On motion duly made and seconded, it was voted that the Council recommend to the House of Delegates that a new charter for the combined societies be issued, provided the membership of the Alameda County Medical Association approves the merger and provided the charters of the two existing societies are surrendered to the Secretary of the C.M.A. for cancellation not later than November 1, 1950.

7. *Public Policy and Legislation:*

Dr. Murray discussed several items of legislation now before Congress and urged that all physicians take an active interest in the June primary elections. On motion duly made and seconded, it was unanimously voted to send a resolution of sympathy and best wishes to Mr. Ben Read, executive secretary of the Public Health League of California, currently recovering from surgery.

8. *Membership of Industrial Accident Fee Committee:*

A letter from an anesthesiologist, asking that a representative of that specialty be named to the Committee on Industrial Accident Fees, was read and discussed. On motion duly made and seconded, it was voted to maintain the present composition of this committee.

9. *Meeting Place for 1951:*

Discussion was held as to a meeting place for 1951 and invitations from Los Angeles, San Francisco, Long Beach and San Diego were presented. It was agreed to discuss this matter further at the meeting of May 1, 1950.

Adjournment:

At this point, the meeting was adjourned, to meet again at 7:30 a.m., Monday, May 1, 1950.

* * *

371st Meeting

Tentative Draft: Minutes of the 371st Meeting of the Council, Hotel del Coronado, Coronado, Monday, May 1, 1950.

The meeting was called to order by Chairman Shipman at 7:30 a.m., Monday, May 1, 1950, in the Patio Dining Room of the Hotel del Coronado, Coronado, California.

Roll Call:

Present were President Kneeshaw, President-elect Cass, Speaker Alesen, Vice-Speaker Charnock, Councilors Ball, Crane, Henderson, Anderson, Ray, Montgomery, Lum, Pollock, Green, Shipman, Bailey, West, MacLean, Frees and Thompson, and Secretary-Treasurer Garland. Absent for cause: Editor Wilbur.

Present by invitation were Dr. Dwight H. Murray, legislative chairman; Dr. Wilton L. Halverson, State Director of Public Health; Dr. John W. Cline, A.M.A. Delegate; executive secretary Hunton, field secretary Clancy, legal counsel Hassard, county society executive secretaries Gillette of Fresno, Venables of Kern, Tobitt of Orange, Young of San Diego, Kihm of San Francisco, Wood of San Mateo and Donovan of Santa Clara; Messrs. Clem Whitaker, Clem Whitaker, Jr., James Dorais and Ned Burman of public relations counsel, and Drs. Frank A. MacDonald, Leopold Fraser, Elizabeth Mason-Hohl, Ralph B. Eusden, E. Vincent Askey, C. Kelly Canelo, Robertson Ward, L. Duke Mahannah, Eugene F. Hoffman and Frederic Ewens, all delegates or alternates to the American Medical Association.

1. *State Department of Public Health:*

Dr. Wilton L. Halverson, State Director of Public Health, reported that an advisory committee to his department's division of crippled children's services had been appointed and that this committee included Dr. Hartzell Ray as a representative of the Council. He also reported that a Committee on Morbidity Survey had met and urged that a careful study be made before any survey of morbidity be undertaken.

In response to a question by Dr. Robertson Ward, C.M.A. Delegate to the A.M.A. and chairman of the A.M.A. House of Delegates' Committee on Chronic Diseases, Dr. Halverson stated that he would forward to the Council the approximate cost of a survey of venereal disease which was undertaken in San Francisco in the last three months of 1949, such information to be directed to Dr. Ward.

2. *Los Angeles County Physicians' Aid Association:*

Dr. Elizabeth Mason-Hohl outlined for the Council the organization of the Los Angeles County Physicians' Aid Association, with which the association's Benevolence Committee has been cooperating for several years. She reported that the organization now owns 60 acres of land in the San Fernando Valley and another 35 acres in a desert location, on which it is proposed to build homes for the care of needy physicians or their families under a permanent benevolence program. She asked the continued cooperation of the association in this project.

3. *Legal Department:*

Mr. Hassard introduced to the Council Messrs. Brooks Crabtree and Gerald Driscoll, legal counsel for the San Diego County Medical Society.

4. *A.M.A. Delegates:*

Dr. E. Vincent Askey, chairman of the California delegation to the A.M.A., solicited instructions or suggestions for the delegation for the June 1950 A.M.A. meeting.

5. *Los Angeles Resolution on Fees:*

Dr. Ben Frees presented a resolution which was adopted by the Council of the Los Angeles County Medical Association earlier this year, relative to a clear understanding between physicians and patients as to fees to be charged. (This resolution is attached hereto and made a part of these minutes.)

On motion duly made and seconded, it was voted that the Council make arrangements for publicizing this resolution.

Adjournment:

At this point, 8:45 a.m., the Council adjourned, to meet again at 7:30 a.m., Tuesday, May 2, 1950.

* * *

Addendum to Minute No. 5, 371st meeting of the Council, May 1, 1950:

RESOLUTION

WHEREAS, The number of written complaints against members reaching the office of the association has increased during the past year to alarming proportions, therefore constituting a most serious problem in public relations; and

WHEREAS, The handling of these complaints in an attempt to be fair to both complainant and member involved has become a task beyond the ability of committees to handle in fairness to all parties involved; and

WHEREAS, Approximately 85 per cent of the complaints, both regarding fees and professional conduct, indicate a lack of understanding on the part of the patient as to what fees might be expected or as to the services rendered by the doctor; and

WHEREAS, A most important step in grass roots public relations is to eliminate as much as possible complaints of all kinds against members; therefore, be it

Resolved: By the Council of the Los Angeles County Medical Association that all members be requested, before service is rendered to a patient, to inform that patient as accurately as possible, the cost of such service, whether it be medical care or surgery, and to inform the patient of fees other than the physician's fees (assistant surgeon, anesthetist, laboratory, hospital, etc.) to avoid any possible complaint relative to fees charged; and be it further

Resolved: That it be the sense of this Council that in a complaint against a doctor relating to fees, in which the doctor has not informed the patient of the fee involved for the service, that such doctor will appear in an unfavorable light when such complaint is studied by the committee handling such complaint; and be it further

Resolved: That a copy of this resolution be mailed to every member of the association; and be it further

Resolved: That steps be taken at once through widespread publicity and advertising, to inform the public that matters of fees for medical service should be arranged with the doctor before services are rendered.

* * *

372nd Meeting

Tentative Draft: Minutes of the 372nd Meeting of the Council, Hotel del Coronado, Coronado, Tuesday, May 2, 1950.

The meeting was called to order by Chairman Shipman at 7:30 a.m., Tuesday, May 2, 1950, in the Patio Dining Room of Hotel del Coronado, Coronado, California.

Roll Call:

On roll call, all officers and Councilors and Secretary-Treasurer Garland were present. Absent for cause: Editor Wilbur.

Present by invitation were Dr. Dwight H. Murray, legislative chairman; legal counsel Hassard, field secretary Clancy, county society executive secretaries Waterson of Alameda, Gillette of Fresno, Wood of San Mateo and Young of San Diego; Ned Burman of public relations counsel; and Hon. Sam

L. Collins, Speaker of the Assembly of the California State Legislature.

1. *Public Policy and Legislation:*

The Chairman presented Hon. Sam L. Collins, Speaker of the Assembly of the California State Legislature, who spoke on the importance of every physician working for a full vote at the coming elections. Mr. Collins also urged consideration of the importance of the coming reapportionment of California's Congressional districts.

2. *Hospital Facilities:*

Discussion was held on the situation in one local community where the only hospital is owned and operated by an osteopathic physician and surgeon. President Kneeshaw emphasized his belief that while the ethical considerations were primarily for county society decision, an over-all association policy would constitute guidance which would be desirable in the interests of harmony and uniformity throughout the state. It was agreed to refer this matter to a special committee consisting of Drs. Pollock, Askey and Montgomery, with a request that the committee evolve a statement of policy which could be a state level guide to the component county societies.

3. *Thanks to Committees, Woman's Auxiliary, etc.:*

It was regularly moved, seconded and voted that the Council extend a special vote of thanks to all committees for their work during the preceding year, to all committees connected with the annual session of the association, to the Woman's Auxiliary and to affiliated groups.

4. *Review of Procedures in C.M.A. Office:*

It was regularly moved, seconded and voted that the Auditing Committee should request the new auditor to prepare an analysis of business methods and procedures in the association office and to offer suggestions for improvement in same, where and if necessary.

5. *Meeting Place for 1951:*

On motion duly made and seconded, it was voted to hold the 1951 Annual Session at the Biltmore Hotel, Los Angeles, at dates to be determined.

Adjournment:

At this point the Council adjourned, to meet again at 7:30 a.m., Wednesday, May 3, 1950.

* * *

373rd Meeting

Tentative Draft: Minutes of the 373rd Meeting of the Council, Hotel del Coronado, Coronado, Wednesday, May 3, 1950.

The meeting was called to order by Chairman Shipman at 7:30 a.m., Wednesday, May 3, 1950, in the Patio Dining Room of Hotel del Coronado, Coronado, California.

Roll Call:

Present were President Cass, President-elect MacLean, Speaker Alesen, Vice-Speaker Charnock, Councilors Ball, Crane, Henderson, Dau, Ray, Montgomery, Lum, Pollock, Green, Shipman, Bailey, West, Heron, Frees and Thompson, and Secretary-Treasurer Garland. Absent for cause: Editor Wilbur.

Present by invitation were Dr. Dwight H. Murray, legislative chairman; executive secretary Hunton, legal counsel Hassard, field secretary Clancy, county society executive secretaries Wood of San Mateo, Waterson of Alameda, Tobitt of Orange, Kihm of San Francisco, Donovan of Santa Clara; Messrs. Clem Whitaker, Jr., and Ned Burman of public relations counsel.

1. *Organization of Council*

Dr. Shipman acted as chairman, pending election of a chairman, and introduced Councilors Neil Dau of Fresno (succeeding Axcel E. Anderson) and Ivan C. Heron of San Francisco (suceeding H. Gordon MacLean) to the Council.

Nominations were called for Chairman of the Council and on nominations duly made and seconded, Sidney J. Shipman was unanimously elected chairman.

On motion duly made and seconded, Donald D. Lum was unanimously elected Vice-Chairman of the Council.

On motion duly made and seconded, Dwight L. Wilbur was unanimously appointed Editor.

On nomination duly made and seconded, L. Henry Garland was unanimously appointed Secretary-Treasurer.

2. *Naming of Auditing Committee:*

The chairman, with the consent of the Council, appointed Drs. Donald D. Lum (chairman), M. Laurence Montgomery and Ivan C. Heron as members of the Auditing Committee.

3. *Felicitations to Florida State Medical Association:*

It was regularly moved, seconded and voted that the Council send its congratulations to the Florida State Medical Association on the occasion of its successful campaign to elect a United States Senator whose views on health matters were in the interest of improved public health and better standards of medical care.

4. *Committee on Industrial Accident Fees:*

It was regular moved, seconded and voted to request Dr. E. Vincent Askey, chairman of the Committee on Industrial Accident Fees, to furnish the Council with quarterly progress reports which the Councilors might discuss with their respective county medical societies.

5. *Committee on Public Health and Public Agencies:*

Drs. Alesen (chairman), Thompson and West discussed several phases of the activities of the Committee on Public Health and Public Agencies.

Dr. Alesen reported on a meeting with officials of the Bureau of Vocational Rehabilitation of the State of California Department of Education, at which the procedures of the bureau had been reviewed. His committee has suggested to the bureau that an appraisal test of three questions on medical services be asked of all agencies referring applicants to the bureau. These questions would, in effect, be:

1. Is the (medical) service rendered one which the patient can reasonably secure elsewhere?

2. Is the individual required to make some effort to secure these services for himself?

3. Is a charge made for the services and, if so, is the charge in proportion to the service rendered?

Dr. Alesen expressed the belief that the application of such questions would eliminate in great part the criticism levelled at the bureau for providing physical examinations in advance of using a means test to determine eligibility of a candidate for medical services under the rehabilitation program.

Dr. Thompson reported on his attendance at a meeting of the hospital advisory committee of the State Department of Health and stated that efforts are being made in all parts of the state to qualify hospitals to receive state or federal funds now available for hospital construction. He urged that careful attention be paid to this statewide movement.

Dr. West reported that he had met on April 27 with a committee to consider a morbidity survey, the committee representing medical, hospital and other interests, and that the committee had discussed the questions of whether or not such a survey could be made and, if so, whether or not it could be effective.

Dr. West also stated that in his opinion it was still too early to make recommendations on the advisability of physicians accepting fees for services rendered in cases of poliomyelitis where the patient was receiving his care at the expense of a foundation and where no means test was applied in the selection of patients.

6. *Committee on Scientific Work:*

Dr. Garland, chairman of the Committee on Scientific Work, asked the approval of the Council on the suggestion that future annual sessions place more emphasis on large general scientific meetings and encourage a limitation of two meetings on the existing scientific sections. The Council approved this suggestion.

7. *Hospital Facilities:*

Dr. Pollock, chairman of the Council's committee on a local hospital situation, reported that the San Bernardino County Medical Society would review the situation in the light of present circumstances. (See Item 2, minutes of 372nd meeting.)

8. *House of Delegates Resolutions:*

(a) Resolution No. 8 of the 1950 House of Delegates, referring to approval of indemnification insurance, was discussed and it was regularly moved, seconded and voted that this item be referred to the Committee on Medical Economics and the author be so notified.

(b) Resolution No. 16, referring to journal subscriptions for medical students, was, on motion duly made and seconded, deferred for further consideration until after the 1950 session of the American Medical Association (at which similar resolutions are due for presentation).

(c) It was regularly moved, seconded and voted that the chairman of the Council confer with the President of the Board of Trustees of California Physicians' Service relative to Resolution No. 10, dealing with a proposed combination of fee schedule committees.

(d) On motion duly made and seconded, it was voted to refer to the Committee on Associated Societies and Technical Groups for study, Resolution No. 19, referring to the practice of psychology.

9. *Time and Place of Next Meeting:*

It was agreed to hold the next meeting of the Council in San Francisco on a date to be selected by the chairman.

Adjournment:

There being no further business, the Council adjourned at 9:50 a.m.

* * *

374th Meeting

Tentative Draft: Minutes of the 374th Meeting of the Council, San Francisco, May 27, 1950.

The meeting was called to order by Chairman Shipman in Room 220 of the St. Francis Hotel, San Francisco, on Saturday, May 27, 1950, at 9:30 a.m.

Roll Call:

Present were President Cass, President-elect MacLean, Speaker Alesen, Secretary-Treasurer Garland, Editor Wilbur and Councilors Ball, Crane, Dau, Ray, Lum, Pollock, Green, Shipman, Bailey, West, Heron, Frees and Thompson.

Absent for cause: Vice-Speaker Charnock, Councilors Henderson and Montgomery.

A quorum present and acting.

Present by invitation were: Executive Secretary Hunton, Assistant Executive Secretary Wheeler, Field Secretary Clancy, Legal Counsel Howard Hassard; county society executive secretaries Kihm of San Francisco, Tobitt of Orange, Wood of San Mateo, and Young of San Diego; Messrs. Clem Whitaker, Jr., James Dorais and Ned Burman of public relations counsel; Dr. C. A. Broaddus, director of postgraduate activities; Dr. Robertson Ward, representing California Physicians' Service, and Dr. John R. Upton, chairman of the Blood Bank Commission.

1. *Minutes for Approval:*

(a) On motion regularly made and seconded, minutes of the 369th Council meeting, held April 29, 1950, were approved.

(b) On motion regularly made and seconded, minutes of the 370th Council meeting, held April 30, 1950, were approved.

(c) On motion regularly made and seconded, minutes of the 371st Council meeting, held May 1, 1950, were approved.

(d) On motion regularly made and seconded, minutes of the 372nd Council meeting, held May 2, 1950, were approved.

(e) On motion regularly made and seconded, minutes of the 373rd Council meeting, held May 3, 1950, were approved.

(f) On motion regularly made and seconded, minutes of the 221st Executive Committee meeting, held May 3, 1950, were approved.

2. *Membership:*

(a) A report of membership as of May 26, 1950, was received and ordered filed.

(b) On motion duly made and seconded, Dr. Charles H. Bulson was elected to Life Membership.

(c) On motion duly made and seconded in each instance, five applicants were elected to Associate Membership. These were: Wilbur Wood Westfall, Alameda County; Lee N. Clark, Fresno County; Clarice Haylett, Marin County; Herbert Bauer, Sacramento County; Esther L. Maurer, San Diego County.

(d) On motion duly made and seconded in each instance, five applicants were elected to Retired Membership. These were: Alameda County, George Willis Clarke, Ode Taswell Leftwich, and William B. MacCracken; David M. Ghrist, Los Angeles County; Dixi McLean Bingaman, Monterey County.

(e) On motion duly made and seconded, reductions of dues were granted to two applicants who are undergoing postgraduate training.

3. *Financial:*

(a) A report of bank balances as of May 26, 1950, was received and ordered filed.

(b) The Executive Secretary recommended that certain bank accounts be consolidated with other accounts as a means of eliminating unnecessary accounting procedures. On motion duly made and seconded, it was voted to recommend this procedure to the independent auditors.

4. *Advisory Planning Committee:*

Mr. Hunton reported that the Advisory Planning Committee had met the previous day and had elected him as chairman, Mr. Waterson of Alameda County as vice-chairman and Mr. Clancy as secretary. He reported the consensus of the committee on House of Delegates Resolutions Nos. 2 and 7: On No. 2 the committee recommended that the existing negotiating committee on industrial accident matters be given the responsibility of the resolution, and on No. 7 it recommended that the county society executive secretaries be used as the starting point to gather information on existing prepayment plans.

On recommendation of the committee, Messrs. Robert Wood, executive secretary of the San Mateo County Medical Society, and William P. Wheeler of the C.M.A. staff were elected to the committee by the Council.

The committee recommended that the Council give serious consideration to the holding of a two-day interim sessions of the House of Delegates in the fall of the year.

The committee recommended that comment be deferred until further study is possible on the proposal of another state medical association for a health program on a national scale.

5. *House of Delegates Resolutions:*

(a) Resolution No. 2 of the 1950 House of Delegates was discussed and it was regularly moved, seconded and voted to refer this matter to the Committee on Industrial Accident Fees.

(b) On motion duly made and seconded, it was voted to request the executive secretaries of the county medical societies to refer to the office all material they could assemble on organizations writing prepayment medical care contracts in their respective areas.

6. *Executive Session:*

At this point the Council went into executive session, rising therefrom before proceeding to the next item of business.

7. *American Public Health Association:*

On motion duly made and seconded, it was voted to authorize Dr. Louis Regan to represent the Association at the annual meeting of the American Public Health Association and to make suggestions for the arrangement of some of the contemplated programs of the meeting.

8. *Public Policy and Legislation:*

Mr. Clancy discussed the primary elections and urged that all members cast their ballots.

9. *Committee on Postgraduate Activities:*

Dr. Charles A. Broaddus, director of postgraduate activities, requested clarification of his authority, particularly in regard to using a symbol and a label on his correspondence, attending a national conference on postgraduate programs and coordinating the postgraduate program with the programs of other organizations.

On motions duly made and seconded, it was voted to permit the director of postgraduate activities to use a printed symbol for his correspondence, to use the standard letterhead for the committee's work, and to coordinate his activities with those of the Cancer Commission and other organizations which take training programs to the rural areas.

The Council disapproved the director's presence at the national conference and the suggestion of having commercial exhibits at the two-day postgraduate institutes being planned.

A proposal of the American Legion for a pediatric program was ordered referred to the Committee on Postgraduate Activities.

10. *California Physicians' Service:*

Dr. Robertson Ward, a Trustee of C.P.S., reported to the Council on the actions of the Board of Trustees on decisions taken by the Administrative Members at the 1950 Annual Session. Dr. Donald Cass, also a C.P.S. Trustee, reported that notice of intention to discontinue the present joint operations of C.P.S. and Hospital Service of Southern California as of December 1, 1950, had been given by Hospital Service of Southern California.

Discussion was held on the request of C.P.S. Trustees for an expression of opinion on the advisability of recognizing the services of chiropodists where such services were sought on the referral by a physician member of C.P.S. On motion duly made and seconded, it was voted to request the C.P.S. Board of Trustees to withhold such recognition.

On motion duly made and seconded, Dr. Russell G. Frey of Red Bluff was nominated as chairman of the C.P.S. Fee Schedule Committee and Dr. Fred Veitch of Riverside was nominated to membership on the committee, to succeed Dr. Harold M. F. Behneman, resigned.

11. *Blood Bank Commission:*

Dr. John R. Upton, chairman of the Blood Bank Commission, reported that seven blood banks of the community type are now in operation in California and that the Tri-County Blood Bank, located in Santa Barbara to serve Santa Barbara, San Luis Obispo and Ventura counties, will open in June.

Dr. Upton recommended that $12,000 of the revolving loan fund be earmarked for San Diego, to be made available as soon as needed when and if the San Diego County Medical Society takes over the proprietorship of the blood bank now operating in San Diego as a joint venture of the City and County of San Diego, the Red Cross, the U. S. Navy and the county medical society. The Council of the San Diego County Medical Society has voted to take over this blood bank if certain conditions can be met.

On motion duly made and seconded, it was voted to establish in accordance with the action of the House of Delegates, a blood bank loan fund of $150,000, funds from which would be loaned for the establishment of community type blood banks under conditions to be drawn up by legal counsel in cooperation with the Blood Bank Commission and approved by the Executive Committee.

On motion duly made and seconded, it was voted to empower the Executive Committee to authorize a special loan of as much as $12,000 to the San Diego County Medical Society for establishment of a community type blood bank.

12. *Legal Department:*

Mr. Hassard reported on various legislative matters which appear in prospect for the 1951 legislative session. He also reported on a recent U. S. Supreme Court decision which held that a schedule of real estate commissions adopted by a local real estate board was a restraint of trade; this decision is the first to hold that standard fees for personal services may be held in restraint of trade.

Discussion was held on the proposals of some organizations to request physicians to recognize as maximums a set of fees for various surgical procedures. On motion duly made and seconded, it was voted that the Association advise county medical societies not to participate in plans to abide by fee schedules devised by two or more competitive health insurers and that any tentative steps taken by their members in such matter be held in abeyance. It was agreed that a summary of the Supreme Court decision be made a part of this communication.

On motion duly made and seconded, it was voted to appropriate $5,000 for the work of the committee on other professions, Dr. H. Gordon MacLean, chairman.

13. *Public Relations:*

Mr. Clem Whitaker, Jr., reported that his office had been working with the committee on medical students, interns and residents and that a new format had been chosen for the committee's publication *Future* so that the title would hereafter appear as *Future M.D.*

Mr. Whitaker requested approval of announcement to be made on the Association's radio program, relative to fees and the costs of medical and hospital care, and approval was granted.

Mr. Burman of Whitaker & Baxter reported that the drive to secure resolutions in opposition to compulsory health insurance was going well. He also reported that the radio program "California Caravan" was enjoying a new high listener rating.

14. *California State Board of Nurse Examiners:*

On motion duly made and seconded, it was voted to nominate Doctors R. Stanley Kneeshaw and Frank A. MacDonald for appointment to the advisory committee of the California State Board of Nurse Examiners.

15. *National Society for Medical Research:*

On motion duly made and seconded, it was voted to refer to the Executive Committee the request of the National Society for Medical Research for a contribution toward its work, with power to act.

On motion duly made and seconded, it was voted to empower the Executive Committee to investigate the needs in Los Angeles County for research and teaching animals and to appropriate up to $10,000 if the need for antivivisection counter-campaign funds is deemed imperative.

16. *Request of New Jersey Delegates to A.M.A.:*

Discussion was held on the request of the Medical Society of New Jersey for cosponsorship in the A.M.A. House of Delegates of a proposed national health plan. On motion duly made and seconded, it was voted to withhold comment on this proposal and to forward it to the California delegates to the A.M.A.

17. *Request for County Medical Society Charter:*

The Council considered a request that a new county medical society charter be recommended by the Council to the House of Delegates for Trinity County. On motion duly made and seconded, it was voted to deny this request on grounds of impracticability.

18. *Committee on Scientific Work:*

Dr. L. Henry Garland, chairman of the Committee on Scientific Work, presented a proposed schedule for the 1951 Annual Session, which would call for meetings of the House of Delegates at 1 p.m. on the first and third days of the meeting. On motion duly made and seconded, it was voted to adopt the proposed schedule.

19. *House of Delegates:*

On motion duly made and seconded, it was voted to call a special meeting of the House of Delegates, to be held December 16 and 17, 1950, in a place to be determined by the Executive Committee. The specific purposes of the special meeting are to be designated at the next meeting of the Council.

20. *Past Presidents of Association:*

Discussion was held on a proposal that past presidents of the Association be invited to attend meetings of the Council. On motion duly made and seconded, it was voted not to approve this suggestion. It was pointed out that a provision of the proposed Constitution now pending before the House of Delegates would grant the privileges of the floor of the House of Delegates to past presidents of the Association.

21. *Committee on Industrial Accident Fees:*

The chairman reported the resignation of Dr. E. Vincent Askey as chairman of the Committee on Industrial Accident Fees and it was regularly moved, seconded and voted that Dr. Francis J. Cox of San Francisco be named as chairman. It was also voted that Dr. Russell G. Frey of Red Bluff, chairman of the C.P.S. Fee Schedule Committee, be named an ex-officio member of this committee, in order to correlate the work of the two committees.

22. *Committee on Grievances:*

On motion duly made and seconded, it was voted to appoint Dr. Hans Hartman of Modesto as a member of the Grievance Committee.

23. *Committee on Advertising:*

On motion duly made and seconded, it was voted to accept the resignation, with regret, of Dr. John W. Cline as a member and chairman of the Committee on Advertising and to appoint Dr. Walter Beckh as a chairman and Dr. Robertson Ward as a member of this committee.

24. *Resolution on World Government:*

A proposed resolution on world government was presented and considered. On resolution duly made and seconded, it was voted to forward copies of this resolution to all members of the Council for their consideration at the next meeting.

25. *Agricultural Workers:*

On motion duly made and seconded, it was voted to request the State Director of Public Health to urge the Governor to appoint one or more physicians to the Governor's Committee to Survey the Agricultural Labor Resources of the San Joaquin Valley, in order that proper consideration might be assured for the medical aspects of the problem.

26. *Medical Society of the State of California:*

On motion duly made and seconded, it was voted to send a letter to the members of the Association, pointing out that the Medical Society of the State of California is not a part of the California Medical Association.

27. *Executive Session:*

At this point the Council went into executive session, rising therefrom before considering the next item.

28. *Qualification of Officers and Employees:*

The chairman stated that all officers and employees of the Association, with one exception, had qualified for office or employment under Section 9 of Chapter 6 of the by-laws, by subscribing to the oath or affirmation required therein. The chairman further stated that Dr. Garland, appointed by the Council at its organization meeting on May 3, 1950, to the office of Secretary-Treasurer, had declined to comply with the provisions of Section 9 of Chapter 6 of the by-laws. Dr. Garland presented to the Council a written statement of his reasons for declining, and requested that his statement be inserted in full in the minutes. On motion duly seconded and carried, Dr. Garland's request was granted, and his statement appears as Appendix A to these minutes. The Council also agreed to the publication of such remarks as the Editor might wish to make relative to Chapter 6, Section 9, of the by-laws. These remarks appear as Appendix B to these minutes.

The chairman then stated that due to Dr. Garland's failure to qualify for the office of Secretary-Treasurer, said office is vacant, pursuant to ruling of the legal counsel that the provisions of Section 9 of Chapter 6 of the by-laws are mandatory.

It was regularly moved, seconded and voted that a special vote of thanks be offered by the Council on behalf of all the membership to both the Secretary-Treasurer and the Editor for their four years of arduous work on behalf of the Association.

The Executive Committee was directed to select a nominee for the office of Secretary-Treasurer and report back to the Council at the earliest practicable date. The Executive Committee was also authorized to appoint a member of the Council as Assistant Secretary-Treasurer, to serve as Secretary-

Treasurer pro tem until the appointment and qualification of a permanent Secretary-Treasurer.

Adjournment:

There being no further business to come before the meeting, it was adjourned at 5:50 p.m.

SIDNEY J. SHIPMAN, M.D.
Chairman

* * *

Appendix "A"—Minutes of the 274th meeting of the Council—May 27, 1950.

Mr. Chairman and Members:

It is evident that you believe it is your duty to insist I take the "oath of office" recently voted at the Annual Session. May I be permitted to make the following observations?

The purposes of the C.M.A. as described in the constitution are "To promote the science and art of medicine, the protection of public health, and the betterment of the medical profession; to promote similar interests of its component county societies and to unite with similar organizations in the other states and territories of the U. S. to form the A.M.A." Active membership requires that the person shall hold the degree of "doctor of medicine issued by an institution of learning, accredited at the time of conferring such degree by the A.M.A. or the Association of American Medical Colleges."

The association is therefore essentially a group of professional persons devoted to improving the quality of public health and raising standards of the medical profession. It is non-sectarian, non-political and non-compulsory.

* * *

The following is the wording of the oath of office as adopted by the House:

"All officers and employees of the Association, upon election or appointment, shall subscribe to an oath or affirmation as follows: 'I do not belong and have not belonged to any organization advocating the overthrow or change of the form of government of the U.S.A. by violent or unlawful means.' If, after full hearing, the Council shall find that an officer or employee falsely subscribed to the oath of affirmation, it may in its discretion remove the officer or employee from his office or position and fill the vacancy so created."

* * *

My comments are nine:

1. The oath is designed to keep Communists out of our organization. Will it? Lenin wrote that "morality is entirely subordinate to the interests of the class war." When it will serve the Red cause, mendacity is not only permissible, it is a duty! The case histories of Alger Hiss, Whittaker Chambers and others suggest they would have been the first to subscribe to such a loyalty pledge.

2. The oath is essentially a *political test.* It sets a grave precedent. Will we be asked next year to swear we do not belong and never have belonged to the Republican Party? Please remember, the Communist Party is still a legal political party in this country. Can we fight its ideas with affidavits?

3. The C.M.A. is a professional organization, non-political and non-compulsory. Indeed, two of its main planks are freedom of choice of physician and freedom of choice of voluntary health plan. It is against politically controlled, compulsory medical schemes. Yet it now proposes to enforce a politically designed, compulsory loyalty oath. Is this not an undignified paradox?

4. The oath is a sister effort of the new House of Delegates oath, which goes far beyond any question of loyalty: This "delegates' oath" involves past or present membership in *any organization merely held to be subversive by a U. S. Department of Justice* . . . not found or proven, mind you, but merely *held* by some person in Washington so to be. There are many distinguished physicians in the C.M.A. who have given donations to such organizations as Chinese War Relief, Spanish Wounded Veterans, Polish War Relief, etc. They are often listed as benefactors of humanitarian or welfare causes, both with and without permission. These organizations change directorship, and directions, from decade to decade. The web is indeed broad, and potential victims numerous.

5. The oath discriminates against those members who desire to work for their profession as employees or officers, but who also wish to maintain their constitutional freedoms—freedom of opinion and association.

6. It may be asked, will our patients also be required to take an oath? Remember the history of the Nazi oath—starting with loyalty to Germany and ending with an oath to Hitler. And Hitler too was an anti-Communist when it suited his purpose!

7. The oath of loyalty is or was most common in those countries where freedom is least: Witness Nazi Germany, Fascist Italy and Stalinist Russia. State or national medical organizations (to paraphrase President Conant) "are neither government bureaus nor private corporations. The criteria for joining a community (of professional persons) are not to be confused with the requirements of a Federal bureau."

8. The oath is degrading to the dignity of a profession which holds the public weal in greater esteem than does perhaps any other. Oaths do not fight the Kremlin; deeds, professional, scientific and organizational, do. The quality of our medical care in the U. S., our ability to mobilize for peace as well as for war is what counts. Let us not distract ourselves with undignified declarations; let us pursue deeds and tangible achievements.

9. Let us dismiss our officers, employees and delegates for true cause—incompetence, dishonesty, neglect of duty, physical or mental incapacity, conviction of moral turpitude—but not for upholding the Constitution of the United States!

* * *

In summary, it seems to me that the oath is foreign to the professional purposes of the C.M.A.,

is of unproven value in accomplishing its aims, and negates the basis of American democracy—the ability to win against all other concepts in a free society. It looks like the beginning of political regimentation in the C.M.A. May I respectfully urge its suspension as of this date, and the introduction of a Council resolution for its repeal at the 1951 Session? Suspension might be extralegal—but so are many acts of statesmen in time of war, whether "cold" or otherwise.

* * *

Finally, may I state that I personally do not belong and have not belonged to any organization advocating unlawful overthrow or change of our government, nor do I believe in the philosophy of Communism or Stalinism. I am for freedom and the democratic type of government. If the Council insists on this oath, I must in effect and with the deepest regret tender my resignation. If this is necessary, I must again thank the Council for the honor and privilege of serving the Association, a service which I have attempted to fulfill with the same diligence and sincerity as that with which I served the U.S.N.R. for some 15 years, including over three on active duty in World War II. This plea to reason, tolerance and justice is spoken on behalf of all the members of our Association.

L. H. GARLAND, M.D.

* * *

Appendix "B"—Minutes of the 274th meeting of the Council—May 27, 1950.

Mr. Chairman and Members of the Council:

I have not taken the oath recently prescribed by the House of Delegates and wish to make the following statement.

Four years ago John Cline asked me if I would be willing to assume the duties of Editor of the then official journal, *California and Western Medicine*. I accepted because, while it involved a good deal of work, I felt the journal could be considerably improved to the benefit of the C.M.A., that as a member of the organization I was under obligation to do my part to further its work and most important, because it was my understanding that no unreasonable restrictions were placed on my conduct of the journal's affairs.

The most recent House of Delegates has placed a restriction on the Editor as an officer of the C.M.A., and it is, therefore, my personal duty to give careful consideration to the limitation which has been placed upon me. The resolution, No. 18, adding section 9 to Chapter VI of the by-laws of the association, requires that an oath or affirmation be subscribed to as follows: "Section 9—Oath of Office —All officers and employees of the Association, upon election or appointment, shall subscribe to an oath or affirmation as follows: 'I do not belong and have not belonged to any organization advocating the overthrow or change of the form of government of the U. S. A. by violent or unlawful means nor do I believe in changing the form of government of the U. S. A. by violent or unlawful means.' If, after full hearing, the Council shall find that an officer or employee falsely subscribed to the oath or affirmation, it may in its discretion remove the officer or employee from his office or position and fill the vacancy so created."

The obvious purpose of this oath is to prevent Communists from holding office in the C.M.A. I have no quarrel with the intent of the resolution and by-law for I have no more desire than does anyone else to be associated with or dominated by Communists. My own experience and that of others leads me to believe that such political oaths are entirely out of place in a non-political scientific organization and, therefore, wrong in principle. Furthermore, they are ineffective in operation and cause much unnecessary dissension and strife—which is exactly what Communists want. It plays directly into their hands.

Not only is such an oath wrong in principle in a non-political, non-sectarian and non-compulsory organization, but furthermore it carries the implication that for a loyal American an oath of allegiance to the United States and to its Constitution is not enough. Something more must be sworn to—that one is not a member of certain organizations and that for members of the House of Delegates one ". . . is not and has not been at any time a member of any organization listed, published or held to be subversive by the Department of Justice . . ."

These are steps towards limitation of freedom, imagination and initiative. It is not too much to suggest that such oaths may lead to other oaths which currently seem harmless, that one is not a Socialist, a Methodist, or a Republican. As John T. Flynn has so well pointed out in his book, "The Road Ahead," a small group of Socialists in England in 1883 organized the Fabian Society which, while apparently innocent at the time, gradually swept forward. Winston Churchill has said that for a thousand years no alien has been able to invade the shores of England. Nonetheless, Karl Marx and his Socialists have done it. Consider the fate of "conquered" England today. Movements in many respects similar in other countries have led to several sorts of "isms" which we want no part of here.

Finally, such oaths are wrong in principle because they are in essence thought policing.

An anti-Red oath is totally ineffective in operation. Certainly it would stop no Communist. He would be the first to take it as experience elsewhere has already indicated. How many Communists have been turned over to the FBI or resigned from offices of authority anywhere because of such an oath?

In this country political oaths, other than of allegiance to the United States, and of a willingness to preserve, protect and defend its Constitution, are redundant. They are the cause of great dissension. Anyone desiring proof of this fact need only read the minutes of the Board of Regents of the University of California and the daily press during the past year. Does anyone gain by such dissension? Is any true purpose served? Only for those who desire dissension and strife.

I have had the privilege of serving my country on active duty in the Navy during World War II. I have also acted in various capacities for the Department of the Army, the Veterans Administration and the National Research Council. No other oath was required of me than that to preserve, protect and defend the Constitution of the United States against all enemies. The state and city in which I live, the various other medical and lay organizations of which I am a member, the university of whose faculty I am a member, the hospital staffs to which I belong, my associates, my patients, my family and above all my conscience do not require me to take an anti-Red oath. Why, then, does the California Medical Association impose this restriction upon me?

Is any political oath really necessary for an officer of the California Medical Association? I do not believe it is. However, if the decision is made that it is necessary, let it be an oath that any American can be proud to take—that of allegiance to the United States and to protect, preserve and defend its Constitution. This oath has been good enough for every President of the United States, for every Chief Justice of the Supreme Court and of the United States, for every holder of high executive office in our Government, for every Senator and member of the House of Representatives, for every officer and enlisted man in our armed forces. It is an oath that everyone can understand, it is positive, not negative, and it is one that only a privileged small percentage of the people in the world can take.

If an anti-Red or political oath is required by the C.M.A., then let it be this oath. There has never been a better one.

. . . After considerable deliberation based in large part on the inability of the Council to alter the oath or the requirement of taking it because it is a by-law of the association, I have agreed to take the oath of office under protest and with the fervent hope that the House of Delegates at its next meeting will abolish this troublesome requirement for the reasons I have previously stated.

DWIGHT L. WILBUR, M.D.

Executive Committee Minutes

Tentative Draft: Minutes of the 221st Meeting of the Executive Committee, Hotel del Coronado, Coronado, Wednesday, May 3, 1950.

The meeting was called to order by Council Chairman Shipman at 9:45 a.m., Wednesday, May 3, 1950, in the Patio Dining Room of Hotel del Coronado, Coronado, California.

Roll Call:

Present were President Cass, President-elect MacLean, Council Chairman Shipman, Speaker Alesen, Auditing Committee Chairman Lum, Secretary Garland. A quorum present and acting. Present by invitation were executive secretary Hunton and legal counsel Hassard.

1. *Election of Chairman:*

On nomination duly made and seconded, Dr. Donald D. Lum was elected chairman of the Executive Committee.

Adjournment:

There being no further business to come before the meeting, it was adjourned at 9:50 a.m.

In Memoriam

DUNNE, GERALD P. Died in San Bernardino, May 8, 1950, aged 62. Graduate of McGill University of Medicine, Montreal, 1924. Licensed in California in 1943. Dr. Dunne was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

FOUNTAIN, EDWIN R. Died in Santa Ynez, May 12, 1950, aged 66, of a heart attack. Graduate of Northwestern University Medical School, Chicago, 1911. Licensed in California in 1914. Dr. Fountain was a member of the Merced County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

HARMON, GEORGE A. Died in San Francisco, April 13, 1950, aged 53, of a cerebral hemorrhage. Graduate of Rush Medical College, Chicago, 1927. Licensed in California in 1927. Dr. Harmon was a member of the Placer-Nevada-Sierra County Medical Society, the California Medical Association, and the American Medical Association.

✤

HART, WILLIAM E. Died in Long Beach, May 14, 1950, aged 79. Graduate of the University of Illinois College of Medicine, 1898. Licensed in California in 1924. Dr. Hart was a retired member of the Los Angeles County Medical Association, and the California Medical Association.

✤

HAYHURST, JOSEPH O. Died in Los Angeles, April 29, 1950, aged 73, of coronary thrombosis. Graduate of Barnes Medical College, St. Louis, 1907. Licensed in California in 1939. Dr. Hayhurst was a retired member of the Los Angeles County Medical Association, and the California Medical Association.

✤

HEULER, LEO. Died in Fellows, April 15, 1950, aged 60. Graduate of Jefferson Medical College of Philadelphia, 1913. Licensed in California in 1914. Dr. Heuler was a member of the Kern County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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WINDHOLZ, FRANK S. Died in San Francisco, April 29, 1950, aged 53, of high blood pressure. Graduate of Carl-Franzens Universität Medizinische Fakultät, Graz, 1922. Licensed in California in 1943. Dr. Windholz was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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WOOD, CLIFFORD H. Died in Glendora, March 30, 1950, aged 71. Graduate of the University of Southern California, School of Medicine, Los Angeles, 1905. Licensed in California in 1906. Dr. Wood was a retired member of the Los Angeles County Medical Association, and the California Medical Association.

C.M.A. House of Delegates Proceedings

April 30, 1950

The first meeting of the house of delegates 1950 annual session (47th annual session) was held in the Ball Room, Hotel del Coronado, Coronado, California, Sunday, April 30, 1950. The meeting was called to order at 5:15 p.m. by the speaker of the house, L. A. Alesen, who presided.

SPEAKER ALESEN: Will the house please come to order? Will the delegates please be seated?

The chair recognizes Dr. Wilcox of Santa Barbara, who will give us a report of the Credentials Committee. Dr. Wilcox.

DR. ALFRED B. WILCOX (Santa Barbara): Mr. Speaker, there is a quorum present in the house of delegates.

SPEAKER ALESEN: It is now in order to move the acceptance of the report of the credentials committee, and in effect this constitutes a roll of this house.

. . . It was moved, seconded and carried that the report of the Credentials Committee be accepted. . . .

SPEAKER ALESEN: The first order of business is the announcement of the various committees required by the by-laws.

Dr. George C. Holleran of Imperial was appointed chairman of the Credentials Committee. We have just had a wire from Dr. Holleran telling us that he is not able to be present. Dr. Frey of Red Bluff and Dr. Wilcox of Santa Barbara are carrying on these duties.

Reference Committee No. 1, on the reports of officers, the council and standing and special committees, T. Eric Reynolds of Alameda County, chairman; Leslie B. Magoon of Santa Clara County and Ralph Teall of Sacramento County.

Reference Committee No. 2, on finance, to review the reports of the secretary-treasurer and the executive secretary: Alson R. Kilgore of San Francisco; Stanley R. Truman of Alameda County and G. Wendell Olson of Orange County. We have just regrettedly received word from Dr. Kilgore that he is ill, so we will substitute the name of Allen T. Hinman of San Francisco and ask Dr. Stanley R. Truman to act as chairman of this committee.

Reference Committee No. 3, on resolutions, amendments to the constitution and by-laws and new and miscellaneous business: H. Clifford Loos, Los Angeles, chairman; Wesley S. Smith, San Diego, and Ivan C. Heron of San Francisco.

Reference Committee No. 4, on executive session: Richard O. Bullis, Los Angeles, chairman; Carl M. Hadley, San Bernardino, J. D. Coulter, Lassen-Plumas-Modoc.

Does the house concur and approve of these appointments? Hearing no objections, the speaker assumes they are approved.

At this time it is my pleasant duty to present to you a man who, this morning, at the general meeting, gave what, in my opinion, was one of the most outstanding addresses that a president of the California Medical Association has delivered for a good long time. I was intrigued and beguiled and certainly stimulated by the work that your president did for us when I heard him this morning. I think it is an excellent job.

Ladies and gentlemen of the house of delegates, R. Stanley Kneeshaw, your president! (Applause.)

PRESIDENT KNEESHAW: Thank you, Mr. Speaker, for those very fine words.

Mr. Speaker, house of delegates, and friends and guests: As Dr. Alesen said, I did give an address this morning. You can read it some time later, they tell me, in CALIFORNIA MEDICINE, and so I won't give any speeches tonight. This is not a night for speech making. I have a sore throat anyway from what I did earlier today. There was no water up there or anything else, so I have had a little difficulty in getting over that. But, anyway, this is not for speeches but for business, so my words will be few.

I merely want to publicly thank all of the men who have worked on committees this year and who do the outstanding work for the California Medical Association. I am sure that many of you men do not realize the number of hours and the amount of effort that are spent by the men who work on these committees that are appointed by the council. They do the outstanding work and they have done a splendid job this year. It really is a hard job that they have to do and they are really the work horses of the California Medical Association. The men that work on these committees have much work to do tonight and so I hope that in your deliberations you will use the usual good judgment that you do use, and that is all that I can expect of you. Thank you. (Applause.)

SPEAKER ALESEN: President Kneeshaw, now you have the pleasant duty of making the presentation of the 50-year pins.

PRESIDENT KNEESHAW: Are there any men here tonight who have been in the society 50 years or more? We had a list of the men that was sent in. That list, unfortunately, is tied up somewhere between the ferry and Balboa Park, but if there are any men here, and I am sorry that I have to ask for these names, because we did have a copy of it, but if there are any men here tonight who come under that category, please raise your hands. Are there any here at all? We had word that there were about 12 that came under that category and we were hoping that some of them would be here tonight so that we could award them this little token of esteem that we have for their services to the California Medical Association.

SECRETARY GARLAND: Mr. Chairman, I would suggest we wait until Tuesday to present these men with these pins. Then we will have the list with us.

SPEAKER ALESEN: That would be a good suggestion.

PRESIDENT KNEESHAW: That is just what we will do, then.

SPEAKER ALESEN: Thank you, Mr. President.

At this time the chair wishes to recognize Leslie B. Magoon, chairman of the delegation from Santa Clara County, who has a pleasant duty to perform.

DR. LESLIE B. MAGOON (Santa Clara County): Mr. Speaker and members of the house: The Santa Clara Medical Society has asked and received permission for the holding before this house of a short ceremony which we believe to be of significance to the whole association. At this time I beg leave to introduce the president of the Santa Clara County Medical Society, Dr. Fred Borden.

DR. FRED BORDEN (president, Santa Clara County Medical Society): Mr. Chairman, Mr. Speaker, members of the house of delegates and friends: One of the most important and influential forces in our land today is that of our daily and weekly newspapers. Seven days a week, 24 hours a day, in every section of the country there are at all times members of the newspaper profession watching the newspaper reports, their city editors and service personnel, watching for developments at vital centers and even seeing that when news is made, everyone will know it. The daily lives of all of us are made by what is printed in the papers and we know we do a lot of talking about the power of the press.

All too often, however, we overlook the usefulness of the press. Through the usefulness of the press a great bulk of our population is becoming more adequately informed of the medical care that can prevent illness and save lives. Also, through the usefulness of the press, many doctors are being informed about new medical developments months sooner than if we depended solely on monthly journals. A great public service is being performed by our newspaper reporters in making people more conscious of the medical services that are available to them, either for disease detection, treatment or cure.

The physicians in Santa Clara County felt they would like to reward some of the excellent work being done by newspaper men in our area and so this year we have established a public service award in journalism. This award is open to all newspaper reporters working directly for any newspaper which has a reasonable portion of its circulation in Santa Clara County.

In addition to these newspapers which are actually printed in Santa Clara County, all of the important dailies in the San Francisco Bay Area have a very large circulation in Santa Clara County.

Our award, to be made annually, is to be given either for a single article or a series of articles on a specific subject related to medical care. To be selected for the award, the article or articles must be deemed to render a public service by bringing the public's attention to some specific medical advancement, service or facility to which persons with a knowledge of the existence of such service or facility can either improve their personal health or prolong their life span. Favorable award points will be based on the accuracy of facts appearing in the articles, the attention value of the presentation and its usefulness in public education. We are not considering articles eligible for award which overexaggerate either a favorable or unfavorable condition, which exaggerate promises of cure or unduly promise hopes for cure or recovery on false or unproven promises or which unduly publicize the services or medical treatment attainments of the doctor of medicine engaged in private practice.

Our reason for asking for this time to appear before this house of delegates was for the purpose of announcing the winner of our first public service award in journalism. Ladies and gentlemen, during the week of March 26 of this year, there appeared in the *San Francisco Chronicle* a series of articles on the subject of cancer which merits unusual praise and which constitutes a truly valuable public service. The reporter who wrote these articles took for his theme the vital matter of early diagnosis in the detection and treatment of cancer, writing in an unusual style on a difficult subject.

The author of these articles kept well within the rules prescribed by our committee.

It is with a great deal of pleasure that our Santa Clara County Medical Society salutes and presents our first journalism oscar to Milton Silverman of the *San Francisco Chronicle*. Mr. Silverman, will you please step forward? (Applause.)

Now, Milton, I don't know whether on an occasion like this I should address you as Mr. Milton Silverman or Dr. Milton Silverman. I understand you are fully accredited to both titles. In either case, it is with a great deal of pleasure that I compliment you on your very splendid work which is receiving great praise everywhere and present to you this oscar and also the check in this envelope which goes along as a part of the prize. (Applause.)

MR. MILTON SILVERMAN: Dr. Borden, ladies and gentlemen: I am most delighted and honored to accept this oscar and what is in the envelope for my editors and myself. The envelope, of course, is for myself. I would like to accept this not for any particular job which I have done but rather as a sign of many years of cooperation and many warm personal friendships that have existed between our gang and the Santa Clara gang, without whose help much of our work would be especially difficult, if not altogether impossible.

I realize it is probably appropriate for me at this point to engage in a little dissertation on the subject of what the press thinks of the medical profession, but I understand that it is the function of newspaper men to cover subjects and not talk about them. Thank you very much. (Applause.)

SPEAKER ALESEN: Thank you, Dr. Magoon and Dr. Borden.

I call attention to the fact that it was up to Santa Clara County to lead the way in this particular type of public relations. Some of the rest of us do the talking but Santa Clara, apparently, does the acting.

It has been said in our meetings that there is never a dull moment. One of the moments about to arrive is a little bit less dull than others. It is going to be a pleasure to introduce the person who is about to speak to you. I would like to say one thing. When you see her you don't need to worry about the combination of beauty and brains. She has done an excellent work for the California Medical Association and the American Medical Association. Her beauty is for her husband but her brains are for organized medicine.

Miss Leone Baxter of Whitaker and Baxter.

MISS LEONE BAXTER: Mr. President, ladies and gentlemen: When Whitaker and Baxter come home to California on our too infrequent visits for our tastes, usually our doctor friends say, "Do try to give us some inside information on what is really going on in the national campaign of medicine against socialized medicine." Actually, I have been warned there isn't very much time tonight and the truth is that most of that type of material is unrepeatable in public.

You people hear in CALIFORNIA MEDICINE what they are continually talking about with our leaders through the country in medicine and you are constantly reminded that you are the first ones to protect and preserve the profession, to put a chip on your shoulders and dare the socializers to knock it off. To somnambulent characters I presume it may seem a little peculiar, then, that there are some sections of the country where the people are even too pugnacious, and that is Washington, D. C., where there are some people who feel that medicine ought to try to win the battle for survival somehow without risk of antagonizing the Federal Security Administrator or the Anti-Trust Division of the Department of Justice or the President of the United States.

Not long ago representatives from all states met in Chicago to discuss plans for the national campaign during the coming year. We had been commenting very seriously on the fact that after all of the hard and heartbreaking work, medicine had been trying to go off the deep end, but that we finally were on the offensive. The campaign plans were based on staying there and doing such a constructive job of proving that the medical service problem can be solved under the system we now have and we believe that medicine never need be on the defensive again. Suddenly a man from Washington arose and with great delight and some wit said, "After all this talk about the defensive and offensive, I want to ask just one question. Just how offensive can we get?"

That is a very good question but actually the answer is better. Medicine has been just offensive enough to leaders of compulsory health insurance so that they are beginning to send out word in the last few weeks that they never were for it in the first place. The latest on it has been the very recent public utterance of the Chicago political boss who has said that compulsory health insurance is not a part of the Truman program. He said it is just something that Oscar Ewing dreamed up in his spare time. Seriously, there is a mighty thin line between the line of offense and defense, and, seriously, if we permit men who go to Congress during these coming elections without knowing how they stand on this issue of ours, medicine is going to be on the defensive again or maybe very soon. If we fail to continue as we are now, solving problems of medical service and medical care, medicine will still be on the defensive years from now.

I think this is the time to tell you something of the feelings of other states in respect to California's position. There have been very difficult and often disheartening times during the campaign of the last year and a half but there have been some developments helpful to the managers of the campaign and to the national committees directing it. The feeling in the majority of the states is that California already had pioneered the job and that it had solved many of the problems and that you could help to point the way.

As many of you know, it was at Dr. Cline's suggestion that the A.M.A. board of trustees tried to prepare a handbook for the use of all the states, detailing very carefully the mechanics of the best of the programs for improvement and extension of medical service. Certainly there should be included in this program for the benefit of all of the states, the program developed right here by California doctors and laymen and county medical societies and the C.M.A.

Actually, the announcement of your own C.P.S. catastrophic coverage has given greater impetus to the campaign and to the other states in the campaign than probably any other single thing since its beginning. Other states have recognized the need to find some solution to that particular problem and to put that solution into operation so that the Federal Government won't do it for them, but California pioneered the plan.

It hasn't merely increased California's prestige and stature—it has done a very practical job of bringing other states closer, in fact, to doing a similar job which on their account would require a great deal more work. Our conversations with insurance leaders, nationally, show that it has had a very great effect on the programs of the commercial carriers.

I can't truthfully say, after our talking with medical leaders in every corner of the country, that they all love you here in California, but I can say this: That they certainly respect your pioneering, constructive work, the work that you have done in the past and that you are continuing to do. It has made it a lot easier for the national committee and for the national campaign managers.

I want to tell you that when the campaign is over, as it will be at the end of this year, Whitaker and Baxter are going to be very pleased and very proud that it is California that we are coming home to. Thank you. (Applause.)

SPEAKER ALESEN: Thank you, Miss Baxter. These are the doctors of public relations who have diagnosed our case and prescribed and told us how to spend our money. They have done a good job and an explanation of the present condition will be continued by Mr. Clem Whitaker.

MR. CLEM WHITAKER: Mr. President, Mr. Speaker, and members of the house of delegates: The generous welcome which Miss Baxter and I have received since we arrived here has helped to warm our hearts after a very cold Chicago winter. I have been moved to wonder at the perversity which caused you to send us to that Siberia in the first place, but I am sure that you wished to do us a favor even if it half killed us. Seriously, we are very deeply appreciative of the opportunity that has been given us because we believe that this is the most vital battle in the most crucial struggle of our times.

During the A.M.A. mid-winter meeting in Washington, D. C., Dr. Elmer L. Henderson as president-elect of the A.M.A. made the statement, with respect to our campaign, that American medicine has come a long way in a short time. I believe there is no question about that statement but I don't believe for one moment that we can conclude that the battle is safely over. I think it is time that we took just a very brief look at both the debit and credit side of the ledger. I think it would be a good thing if we looked back to where we stood a year ago and if we looked ahead to some of the problems that now confront us.

A year ago, when the A.M.A. opened its campaign, medicine stood almost absolutely alone without a single national organization willing to take a stand beside it. This issue was considered too hot, too controversial, too dubious for many of the other great groups in the country that believe in America, to take their stand beside the doctors. Today the doctors of America can take credit, for more than 6,000 of these great national organizations of America have publicly taken their stand beside you, condemning public health insurance and promising to lend their aid and their facilities to prevent its enactment. (Applause).

That is a tribute to work at the grass roots but we can't stop there. I hope and I am willing to predict to you that by the end of this year that number will have been doubled.

A year ago we feared to take a roll call of Congress. Let's be absolutely frank about it. If the roll call had been taken last March or April, a year ago, medicine, in all likelihood, would have gone down to defeat, but the newspaper men in Washington, the political leaders in Washington and our own leaders in the A.M.A. were conscious of that condition. I want to bring you this heartening report tonight. It isn't the A.M.A. that fears the roll call. It isn't medicine that fears that issue or that condition now. It is President Truman who will not let the roll be called and, if the roll were called today in the House of Representatives of the United States or the Senate, I can tell you, you would have a grand victory that would be heard in this whole country in its fight against the attempt to socialize this nation. (Applause.)

But again, let me say this. This is only one Congress and Congress changes its complexion every two years. A year ago, and this is a very significant fact because this is the most direct testimony of what you doctors all over America have done, a year ago the mail received by members of Congress was running two and a half to one in favor of socialized medicine. Today, according to the latest check that has been taken, the mail is running three to one against compulsory health insurance. A year ago we were on the defensive but, as Miss Baxter has told you, we are now on the offensive. I think even Oscar Ewing knows that the backfire has come right up to the outskirts of Washington and he has a healthy respect for American medicine; in fact, Mr. Ewing, your chief opponent on this issue next to the President of the United States, is so dispirited that we are very fearful he will resign before the end of the year.

I want to say something about the problems which lie ahead because it isn't enough to think back on the improvements we have made on our position. This improvement has come by the exceedingly hard work by thousands of doctors all over this nation. And if you don't believe that the average practitioner finally is on fire on this issue, I would like to give you a few facts as to some of the jobs that they have done. During the past twelve months over 15,000 speeches have been made by doctors in this country against socialized medicine, ranging from great mass meetings to little meetings in farm areas, the P.-T.A. as well as many other groups, and during that period doctors from their offices have distributed 85 million pamphlets to their patients and friends. During that period we have had the greatest outpouring of mail into Congress on this issue of any issue now pending before the Congress.

We have been called a notorious lobby and a grass roots lobby. I want to say to you, ladies and gentlemen, you can be very proud of that designation—you are a fine, powerful grass roots lobby and it has won the respect of those who possibly would otherwise destroy you. Don't ever let it go down. Don't think for one moment that the politicians don't respect you because you have met them on their own ground and made them backtrack. It has been said that Napoleon and the Kaiser and Hitler never crossed the English Channel, but all we need to do is to look at the daily press today and we know very that Karl Marx did make it. There is no question but that an attempt is being made now to cross to our side of the Atlantic.

This fight in which you are engaged is not just a fight to save medicine. We are all aware of that.

You are giving heart and leadership to all of the American people who had almost lost courage in this fight to save this country from following in the pathetic pattern of Great Britain and other European nations. I look back over the early days of the fight in California when you were first mobilized, when Governor Warren's first bill was put into the legislature, and I think how far has American medicine come since that day. You have learned how to be crusading citizens. You have learned that it is not enough to be a good doctor if you want to survive and yet, too, you have learned that it is imperative that you do everything within your power to improve your doctor-patient relationships, to correct the conditions which have brought criticism upon you.

The American Medical Association is doing everything in its power to stimulate the various states to do the job which you are about to undertake in California, to spring out into a real job of patient-physician relationship, to cure some of these things which have helped bring about this agitation. But do not conclude that this attack has been brought about simply because your public relations have been bad.

Please let me issue this warning to you. Even if you had committed no sin of omission or commission in a public relations way; even if you doctors had never been guilty of overcharging in your fees or if there had never been that type of criticism at all, American medicine would still not be safe because American medicine is, in effect, part of our enterprise system and those who wish to socialize America, just as those who socialized Britain, don't want it broken down to disrupt part of our industrial economy.

They want the successful part of it because it will give them power, over-all power, in this country and because you have demonstrated your efficiency and your initiative in your chosen profession, they know they would not be taking over a sick enterprise. There is only one way that you can remain free and that is that you will stand out against this attempt to bring you under government domination. That is to be prepared at all times; be prepared to answer the attacks with a better counterattack and don't ever let anybody tell you that the battle will be over until we have completely rejected the Truman administration, until we have elected a Congress that will stand up for American things and the American way of life.

When I came out here I was a little bit dejected to learn that there were some in the California Medical Association who felt that the fight was almost over and that it was time that we were pulling our punches and spending our money otherwise, or, perhaps, at least reducing the money expended. Don't misunderstand me—I can appreciate the pressure on the members of this house of delegates from those in their districts who do not understand the seriousness of this case. But let me say this: This is no time to retreat. This is no time to let up. You, this house of delegates of the California Medical Association, brought about this great national campaign. You are the ones who pioneered it. You are the ones who woke up national medicine until the fight was made that saved your profession and this year A.M.A. is going all-out. They are going to spend over $3 million. They are bringing up all of their reserves, all of their resources, to win a decisive victory.

All of the states throughout the Middle West and the East and the other states are being asked to supplement and back that program, and what a travesty it would be at this time if the California Medical Association, which pioneered this great work, started to pull its punches. I am speaking frankly because I have a great affection for most of you and because I have only one interest and that is the interest of your association and the interest of medicine.

I am going to be specific. Yesterday the council asked me to tell you our feelings regarding your million dollar surplus. There are some among you who feel that the dues should be reduced and that the association should use part of that surplus to live on. The question was asked, "What value is that million dollars to California medicine at this time?" I made a statement to the council and I want to make it to you. It has paid you far greater political dividends than the bank has paid you in interest, strength, credit and respect in a world where there is malcontent and those who are determined to destroy you. You took the initiative in the battle in this state three years ago when there was an effort to enact socialized medicine and except for that one million dollars in the bank, you would not have been able to fight it. While this great urgency is upon you, don't ever go out unprepared.

Then I was asked to speak to you on something which is even more controversial, perhaps, than the million dollars and that is the *California Caravan* on your radio program. I want to say this to you with respect to that program. During this year when American medicine is investing $1,100,00 in newspaper advertising, in radio advertising and in magazine advertising, when it is even encouraging all of the tie-in advertising from the drug firms and prepaid health plans and insurance companies and the state and county societies to back up that program, so that you can demonstrate to our friends, to the people, before the election and so that we can dramatize the issues of socialization before the people vote on these candidates, for goodness' sake, don't consider for a moment abandoning the program that speaks to 900,000 people every Sunday afternoon as that program does.

I wonder if you recognize that Governor Warren or Jimmy Roosevelt or either one of them never speaks to 900,000 people at any one political address they give. That is the power you have and a political program, until created, doesn't have that kind of an audience. Whether you ever fire a shot in anger at the *California Caravan*, it is one of the finest defenses that you have.

I probably shouldn't speak a minute longer because I know the time is short. I want to say to you out of the fullness of my heart that this fight against socialized medicine is the biggest thing in your lives. It is bigger than any emergency that has ever confronted any of you as a doctor. Whether you continue to practice as a free man, whether you continue to live in a free America, is going to be determined without fail in the next three or four years.

Senator Taft made the interesting statement very recently that if we elect a radical Congress in 1950 there was no use to elect a different kind in 1952. Senator Taft, even though he would like to be a candidate for President in 1952, knows that. If we lose our congressional elections this year you cannot stop the essential measures of your socialistic program from going through this next Congress if the people turn us down. You have demonstrated a tremendous power not only on Congress but you have demonstrated a power to get this story to the people. But, if in the eyes of Congress, you fall short and do not get your vote out on election day, if you fail to reward your friends and punish your enemies, then medicine will no longer have the respect in Washington that it has today.

I want to say this to you. California, according to Senator Brewster, who is the chairman of the Republican campaign committee of the Senate, and according to Congressman Hall, who is the chairman of the House Committee, has the most dangerous political situation in the congressional elections of any state. The Republican party in this state is exceedingly weak, due to the fact that you don't have Republican leadership — you have personal leadership, and you men and women sitting here don't need to be told that in your California governorship race you have only one choice, the lesser of two evils.

After this election, regardless of who is elected, you will have a hostile governor's office, so you must have a friendly legislature. You must have a Congress that is responsive to American principles and I want to see California, because I love this state and I am proud to come from this state and I have sung its praises all over the country for the job it has done in pioneering—come through this year and help your A.M.A., help your profession and help America to win this very vital fight. Thank you. (Applause.)

SPEAKER ALESEN: Thank you, Mr. Whitaker. It is certainly heartening to hear these remarks by our public relations counsel.

We will now proceed with the regular agenda. First will be the report of the council, Dr. Sidney J. Shipman, chairman.

DR. SIDNEY J. SHIPMAN (chairman of the council): I have a brief additional report. My remarks will not be lengthy.

Supplemental report of the council covering items considered by the council since the printing of its report in CALIFORNIA MEDICINE, as follows:

1. The council has approved the principle of making the payment of American Medical Association dues as well as California Medical Association dues a condition of membership and instructs the chairman of the council and members of the house of delegates to introduce appropriate by-law amendments to carry out this principle.

Mr. Speaker, may I introduce at this time two by-law amendments to this effect.

SPEAKER ALESEN: Yes, please proceed.

Resolution No. 1

DR. SHIPMAN: Amendment to Chapter II, Section 2(b) and Chapter X, Section 1(b) of the by-laws of the California Medical Association.

Resolved: That Section 2, paragraph (b) of Chapter II of the by-laws of the association, California Medical Association, is hereby amended to read as follows:

(b) By failure to pay dues

If the annual assessment of dues, payable to this association and to the American Medical Association by any member of this association, are not fully paid on or before April 1 of any year, such member shall automatically lose his membership in this association as of April 1 of such year. The council of this association, in its discretion, upon payment of such unpaid dues, and any other assessments or dues accruing thereafter, may at any time reinstate such member; and be it further

Resolved: That Section 1, paragraph (b) of Chapter X of the by-laws of this association, California Medical Association, is hereby amended to read as follows:

(b) County secretaries to collect dues

The secretary of each component county society shall cause to be collected and shall forward to the office of this association the dues and assessments for this association and the American Medical Association, as levied upon the members of this association and the American Medical Association who are members of the component county society.

Continuing the report of the council:

2. The county medical societies in Alameda and Contra Costa counties have voted in their respective councils to merge the two into the Alameda-Contra Costa County Medical Society, subject to approval of the merger by a plebiscite of the two memberships.

The council has approved this merger and recommends that a charter be issued to the Alameda-Contra Costa Society if, prior to November 1, 1950, the present charters of the two existing societies have been surrendered to the secretary for cancellation.

3. The council recommends that the house of delegates elect to honorary membership Dr. Alex M. Lesem of San Diego because of his long and distinguished service in the field of public health.

4. The 1949 house of delegates adopted a resolution calling for the appointment of a committee of the house of delegates to study certain phases of California Physicians' Service. This committee has

not been appointed and the council recommends that membership of this committee be selected and announced at this session.

(I may say that I take the responsibility for overlooking this matter. Dr. Bender has called it to my attention in two letters such as only Dr. Bender could write.)

5. The council has approved the report of the Blood Bank Commission which calls for the establishment of a revolving loan fund of $150,000.00. This sum is to be used as starting capital on a matching basis, for the establishment of blood banks in several areas of California in conformity with a statewide plan developed by the Blood Bank Commission.

The council suggests that Dr. John R. Upton, chairman of the Blood Bank Commission, be permitted to discuss this project on the floor of the house of delegates and urges the house to give favorable consideration to the establishment of this loan fund.

6. The council has approved a budget for the 1950-1951 fiscal year which permits a reduction of the dues in the amount of $5.00. It will recommend that the dues for the calendar year 1951 be set at $40.00 per active member.

SPEAKER ALESEN: That part of the council's report dealing with general council problems will be referred to Committee No. 1; that part embracing proposed amendments to the by-laws will be referred to Reference Committee No. 3, and that portion dealing with the recommendation on dues and financial matters will go to the finance committee, Reference Committee No. 2.

The report of the trustees of the California Medical Association, Dr. Stanley Kneeshaw, president—and Dr. Kneeshaw, do you have any further report?

PRESIDENT KNEESHAW: The report is in the preconvention bulletin, page 10.

SPEAKER ALESEN: The report of the Auditing Committee—H. Gordon MacLean, chairman.

DR. H. GORDON MACLEAN: No further report.

SPEAKER ALESEN: The report of the secretary, Dr. L. Henry Garland.

DR. L. HENRY GARLAND: Nothing further to report.

SPEAKER ALESEN: The report of the editor — Dwight L. Wilbur.

. . . Dr. Wilbur was not present. . . .

SPEAKER ALESEN: Report of the district councilors. Does any district councilor wish to give us any further report—apparently not.

The reports of the councilors-at-large — apparently there is nothing further.

The report of the legal counsel, Peart, Baraty & Hassard. Mr. Hassard, do you have any additional report? Apparently not.

Report of standing and special committees: Executive Committee—H. Gordon MacLean.

DR. H. GORDON MACLEAN: No further report.

SPEAKER ALESEN: The Committee on Associated Societies and Technical Groups — Robert A. Scarborough.

DR. ROBERT A. SCARBOROUGH: No additional report.

SPEAKER ALESEN: The Committee on Audits—H. Gordon MacLean. Is there any additional report?

DR. H. GORDON MACLEAN: No further report.

SPEAKER ALESEN: Thank you, sir.

Committee on Health and Public Instruction — Orrin Cook.

DR. ORRIN COOK: No further report.

SPEAKER ALESEN: The report of the Committee on History and Obituaries—Robert A. Peers.

DR. ROBERT A. PEERS: Nothing further to report.

SPEAKER ALESEN: The Committee on Hospitals, Dispensaries and Clinics—Carroll B. Andrews.

DR. CARROLL B. ANDREWS: No additional report.

SPEAKER ALESEN: Thank you.

The Committee on Industrial Practice — Donald Cass.

DR. DONALD CASS: There is no additional report.

SPEAKER ALESEN: The Committee on Medical Defense, Dr. H. Clifford Loos.

DR. H. CLIFFORD LOOS: No additional report.

SPEAKER ALESEN: The Committee on Medical Economics—H. Gordon MacLean.

DR. H. GORDON MACLEAN: No further report, Mr. Speaker.

SPEAKER ALESEN: The Committee on Medical Education and Medical Institutions—L. R. Chandler.

DR. L. R. CHANDLER: No further report.

SPEAKER ALESEN: The Committee on Organization and Membership—Carl L. Mulfinger.

DR. CARL L. MULFINGER: No further report.

SPEAKER ALESEN: The Committee on Postgraduate Activities—John C. Ruddock.

DR. JOHN C. RUDDOCK: No further report.

SPEAKER ALESEN: The Committee on Publications—George Dawson.

SECRETARY GARLAND: No further report has been received.

SPEAKER ALESEN: Now here, ladies and gentlemen, is a case where we are going to have an additional report from the Committee on Policy and Legislation—Dwight H. Murray, who needs no introduction to this house of delegates. Dr. Murray, are you with us? Please come forward.

DR. DWIGHT H. MURRAY: Mr. Speaker, members of the house of delegates: I have in the beginning some bad news but also good news. For about 17 years Ben Read has served you very capably and very well. It was unfortunate that he had to undergo an operation a short time ago, to be exact, Tuesday of last week. The operation was quite successful and the patient is living. The condition for which he was operated, his doctor tells me, will be entirely re-

lieved and we expect to have Ben Read back with us again in about a month or six weeks' time. (Applause.) Thank you very much. You might understand how low I felt when I heard that he had to be operated on.

That means just this. We have some elections coming up and it means that the rest of us have to spread ourselves to cover the vacancy that is left by Ben and that I will expect you to do. I know you will and I am going to tell you shortly some of the things that I feel we have to do.

You heard a few minutes ago from Whitaker and Baxter, you heard that our fight is still on. Some time ago there was a certain man, at that time very prominently connected with American medicine. who said that socialized medicine was as dead as a dodo. That was not true then and it is still not true.

Now, coming to our California problem, the question is asked, "What shall we do about the governor? Shall we vote for this man or shall we vote for the other man?" It is a matter of record for the last ten years that the wishes of the governor, any man who has been governor, had they been satisfied, would have given us socialized medicine in California today. We would not only have it today—we would have had it ten years ago. Nowhere do we now have socialized medicine. What has been our protection? That is a very simple question. The legislature has been our protection and it still is.

Starting somewhere at the top of the list, our lieutenant governor is a very important factor and the man who is a candidate for lieutenant governor to succeed himself has certainly been our friend. He has said so. He has acted so. So, there is no reason in the world why we should not return Lieutenant Governor Knight to the position that he now holds of lieutenant governor.

The attorney general has the power and authority to give us and do us great favors. Our present attorney general has done so. Regardless of all the political fire that you may have heard—and you may realize that some of it has been a lot of, and is bound to be, politics—he has been our friend. To my mind the first principle of politics is to not forget those who have befriended you and I hope you do that with regard to this election.

We have to elect in our state this year only 17 senators. As you know, every two years we have to elect 20 senators normally but this year we have three who are unopposed. Senator Collier from Yreka and Senator George Hatfield from Madera and Merced counties and Senator Burns from Fresno County are unopposed, so that leaves 17 senatorial campaigns for us to consider.

In the assembly, normally, of course, there are 80 seats in the assembly. This year there are 12 who are unopposed. That leaves 68 campaigns.

Now, gentlemen, I want to tell you that we must return to our California Legislature the men that we now have as your friends. We must have them because, apparently, it doesn't make much difference who is elected governor, he is going to do all he can to socialize medicine, and, as I said a minute ago, the legislature is our protection. The legislature can and will protect us if we send the right people there. So let's see to it that in our districts we get the right people.

The time to talk to a man who is running for office is when he is a candidate. Don't wait until after the election. Try to sound him out and see how he feels about some of our problems, but talk to him while he is a candidate. He will listen to you then and he is much more impressionable and he will then remember or, rather, later remember the things he has then said to you.

It is so important that we not only talk to the candidates about the problems of socialized medicine but also the problem of what we call our fringe bills. These give us more headaches really than socialized medicine. What I am speaking about particularly is such bills as the naturopathic bill. Following up what Clem Whitaker said a few minutes ago, we very nearly escaped about four years ago having a naturopathic issue before the ballot for us to combat. That would have been very bad. It would have cost us lots of money. It would have cost us lots of headaches.

Such people as those are liable to come forth at any time. We have not only had the naturopaths but the chiropractors and osteopaths. There is every cult in California that anybody ever thought of. Sometimes some of our friends back East have said, "Well, why did you think that one up?" I have said, "I don't know, they must have come from some place east of the Mississippi."

Let's get busy. We must get our committees formed in the various districts—you have done that before, and you all very well know how to do it. I certainly think that we in California have the know-how. If we will just follow through again and do the job as well as you have done it in the past, I am sure that when the election is over we in the majority will be satisfied.

It is important that we elect as many men at the primary as possible. Here is the danger. If we do not, we are in danger of either one of the men who will be elected governor carrying a certain number of people, as we say, on his coattails. They may not be the men that we would desire to have represent us. So, if we can win at the primaries as many elections as possible, we then escape any threat of any man riding into the office on the coattail of the elected governor.

So far as our problem nationally is concerned, there are a great many bills before the Congress. Mr. Whitaker has stated that we would be glad to have this year, not last year and certainly not two years ago, a roll call on compulsory health insurance, but, of course, Mr. Truman and his gang are a bit astute and they are not going to let such a thing come about. It not being our bill, we can't force it. All we can do is try to needle them but they don't rise to the bait, so we probably will not have that opportunity of having the pleasure of really knocking them down at roll call.

The bills that are before the Congress, and some

of the bills are very similar, are very important to us in medicine, for they include medical education, child health care, and the inclusion in the Social Security Act of disability and many things of that nature. They have taken a lot of our time and attention on the national front.

The bills that have passed the Congress so far this year have not been inimical to our best interests. We hope that this record can be maintained, but when you are dealing with the Washington situation, to say that it is pretty tough is an understatement.

Some of our men are candidates, and I want to say something about them because it is just as important to elect the proper men to the Congress as our very own men in the California Legislature. We have running for the Senate a man who is certainly favorable to us. He is young and aggressive, a well-liked man in the Congress and that is Richard Nixon who is a candidate for the Senate. We must do all we possibly can to see that Mr. Nixon is sent to the Senate. We need him in the Senate. There are 36 vacancies in the United States Senate coming up and we must replace the ones who are going out as well as some of the ones who are there, by good men.

Of course, in the House we have them all to elect. In California we have only one who is unopposed. That is Congressman Engle. He is unopposed. Then we have 22 campaigns for Congress. Some of them are going to be tough campaigns. It is vital and very necessary that we send the proper men back to Washington. You heard Mr. Whitaker quote Senator Taft, and Senator Byrd from Virginia said almost identically the same thing in speaking to us about our position in medicine. He said that if we lose in 1950, 1952 looks extremely dark, so the way, and the only way, we can save the day, is to elect and send to the Congress the proper men.

It is very interesting to watch all of these things but at the same time very difficult. It isn't possible for me, one man, or any two men or any group of men to do it. There again, I want to say to you that it is your job at the grass roots to do this. Maybe you can do it. Nobody knows the candidates like you know them and nobody can approach them like you can, so don't neglect a single opportunity. You have in many of your counties some very capable young men as executive secretaries. I wish that we had an executive secretary in every county. These young men are capable fellows and they will do the thing that is best for us, and let's help them and tell them what to do.

As I told some of them this morning, they aren't worth a damn to look at and, if they didn't do any work, they were a total loss. So let's give them something to do. They can be and they are a great source of help to you, so let's not overlook a single one of them. They will be a tremendous power to us at all times. They can talk to people and they will do things for us that will be of great value from the political point of view.

Let's not overlook many of our friends such as men in industry. I have said this so many times that I almost think my voice is an echo, that if it had not been for our friends in industry, in business, in all walks of life, we would long ago have lost the battle for compulsory health insurance. Let's show them the way, as Mr. Whitaker said a while ago, and they will be glad to follow us. They are still our friends. We have not insulted them. We have not lost any face with any of that group so let's turn to them, also to help us. They can and they will and they are great forces for good in our behalf.

A week ago today the legislative committees of the allied professions met in San Francisco and we discussed every man who is a candidate for election, either for state election or the national election. Those of the allied professions who were present consisted of dentists, hospital administrators, dispensing opticians, pharmacists and physicians. These committees all agreed on every man that we have running for office, either on the state or national front, and they will likewise be ready to help you when you go out on your campaigns. They know because they have been told. They understand and I am glad to say that in many areas the dentists are much stronger in your behalf than they have been for some time; also the pharmacists.

The hospitals already are and we are all working together and there should be no conflict between our groups. We should look to them. If they don't come to you, you go to them and say, "Mr. Pharmacist, here I want you to help us in such and such a campaign; Dr. Dentist, we want you to get together and help us for a committee." Get together a little money for campaign purposes. That is all perfectly legal and all right and you will not be prosecuted for doing that. Thank you very much and I hope that when the campaign is over, we can say that we will again be safe. (Applause.)

SPEAKER ALESEN: Thank you, Dr. Murray.

I wonder if we all realize the amount of time and money that Dr. Murray has put in on legislation. How he has time to practice medicine, I don't know.

Dr. Sidney J. Shipman has an important matter to present to you at this time.

DR. SIDNEY J. SHIPMAN: Mr. Speaker, may I ask the privilege of having the house consider item number 3 on my supplemental report? This is the item, sir, of the election of Dr. Alex M. Lesem to honorary membership in the California Medical Association.

SPEAKER ALESEN: Is there any objection on the part of the house to consider this application at this time? The constitution requires your action and the reason for bringing it in at this time is the fact that we want to get a little notice of this in the papers. This seems to be a most appropriate time to do it. Hearing no objection, the chair will declare the matter to be in order, Dr. Shipman.

DR. SHIPMAN: I move then, Mr. Speaker, that Dr. Alex M. Lesem of San Diego be elected to honorary membership because of his long and distinguished service in the field of public health.

DR. WALTER WESSELS (Los Angeles): I will second the motion.

SPEAKER ALESEN: Is there any discussion?

Dr. Lesem has been one of the outstanding men in the field of public health in San Diego.

Is there any discussion?

. . . There being no discussion, the question was called for and the motion was put to a vote, the motion being unanimously carried. . . .

SPEAKER ALESEN: Let it be recorded, Mr. Secretary, that the vote is unanimous and Dr. Lesem has been elected an honorary member of the California Medical Association.

Is Dr. Lesem here? Will you come forward and let us look at you, doctor?

Mr. Secretary, will you escort Dr. Lesem to the rostrum?

. . . Dr. Lesem was escorted to the rostrum by the secretary, Dr. Garland. . . .

(Rising applause.)

DR. ALEX M. LESEM: Brother physicians and surgeons: In 31 years I have had great honors bestowed upon me for some work, but nothing has affected me more than this honor, being elected an honorary member of the California Medical Association. I deeply appreciate it and I will be glad to work for the interests of the profession and the ranks of the private physicians.

Thank you again. (Applause.)

SPEAKER ALESEN: At this time a motion is in order to recess, to reconvene at 7:45 in this hall.

. . . It was moved, seconded and carried that the meeting recess. . . .

. . . The meeting recessed at 6:30 p.m., to reconvene at 7:45 p.m. . . .

RECONVENING OF HOUSE OF DELEGATES

. . . The house of delegates reconvened at 8:10 p.m. and the meeting was called to order by Speaker Alesen. . . .

SPEAKER ALESEN: Gentlemen, be seated so we may come to order.

The house of delegates will be in order. At this time we will recess the house of delegates and turn the meeting over to the administrative members of the California Physicians' Service, Dr. Lowell S. Goin presiding.

. . . At 8:15 p.m. the house of delegates recessed. . . .

RECONVENING OF HOUSE OF DELEGATES

The house of delegates reconvened at 10 o'clock p.m. The meeting was called to order by Vice-Speaker Donald Charnock, who presided.

VICE-SPEAKER CHARNOCK: The house of delegates will please be reconvened.

The next order of business is the reports of standing committees. The Committee on Scientific Work—Dr. L. Henry Garland.

DR. GARLAND: Nothing additional to report.

VICE-SPEAKER CHARNOCK: The report of the Cancer Commission—Dr. Lyell C. Kinney.

SECRETARY GARLAND: Nothing additional to report.

VICE-SPEAKER CHARNOCK: The Editorial Board —Dr. Dwight L. Wilbur.

SECRETARY GARLAND: Nothing additional to report.

VICE-SPEAKER CHARNOCK: Public relations — John Hunton.

MR. HUNTON: No further report.

VICE-SPEAKER CHARNOCK: The report of special committees: Delegates to the American Medical Association—Dr. E. Vincent Askey.

DR. ASKEY: Mr. Speaker, members of the house of delegates: I will make it very brief because we are late. In the first place, I want to make an announcement. The delegates and alternates to the American Medical Association from the California Medical Association will meet in the patio dining room tomorrow with the council of the California Medical Association for instructions. Our next meeting will be held at 7:30 tomorrow morning. All delegates and alternates to the American Medical Association from California will meet at 7:30 in the patio dining room.

We delegates in whom you have had confidence and to whom you have given your support at all times wish to express our thanks to you, and we want you to know that we want to follow out your instructions. We are going to need an awful lot of help. You heard this afternoon from Mr. Whitaker and Miss Baxter. You heard them tell you that California will lead in many endeavors and many things that will be accomplished. They gave us quite a compliment but we as your delegates feel that that is a compliment to yourselves. We take a great deal of happiness in the fact that with your support we have been able to do some of the things that we feel that you want.

I am getting up to this: In San Francisco the meeting of the American Medical Association will be held beginning June 26 and through June 30. There will probably be many things brought up at that meeting which will be extremely crucial for American medicine. The eyes of American medicine are on California because many things are expected and California is expected to lead. They expect us to lead for many reasons but for one very important reason. There is one of your members sitting in the house tonight who has been a great power for California medicine. He has been a power for American medicine and he is a man in whom we have extreme confidence because he has carried our ball at a great cost to himself. Now we have the opportunity to honor this man for the service he has given us and we have the opportunity to honor this man for the service that he will give to us. California has not had a president of the American Medical Association since our beloved Ray Lyman Wilbur.

There is another man in our audience tonight, a

past president, who we firmly believe and hope will be elected the next president of the American Medical Association. I refer to our past president and worker for medicine, Dr. John W. Cline, and I hope that all of you will be up at San Francisco to give him the rousing support that he deserves.

Dr. Cline, will you arise, please, and take a bow? Dr. Cline! (Applause.)

Thank you very much.

VICE-SPEAKER CHARNOCK: The Committee on Physicians' Benevolence—Dr. Axcel E. Anderson.

DR. ANDERSON: No further report.

VICE-SPEAKER CHARNOCK: The Advisory Planning Committee—John Hunton.

MR. HUNTON: No further report, Mr. Speaker.

VICE-SPEAKER CHARNOCK: The Blood Bank Commission—Dr. John Upton.

DR. JOHN UPTON: Mr. President, Mr. Speaker and gentlemen: I will make it very brief. I wish that the words of Clem Whitaker and his very charming girl had been said by the Blood Bank Commission group because so many of the words that they used this morning were definitely directed and could be spoken by the Blood Bank Commission.

A lot of work has been done by your committee. A lot of work still remains to be done and will be done. We know where we are going. We are going to do it. With your support it is going to be accomplished.

On page 25 of your reports you can read very briefly about some of the accomplishments that have taken place this last year. It will not be necessary to go over those again.

What of the future? Simply this: Two new banks will be in operation this year. One will be in Eureka and the second will be in tri-counties which include San Luis Obispo, Ventura and Santa Barbara counties, with headquarters of the regional bank, the physical plant, in Santa Barbara. These medical societies deserve a great deal of praise for the work that they have done in the planning stages and the work that has to be accomplished and will be accomplished in these centers where blood is not being given in adequate quantities but where it can be made available to you men in adequate quantities.

There is the Riverside and San Bernardino region. That is one area. Bakersfield is an area. Los Angeles is an area. There is the Redding-Red Bluff area.

These problems will be taken on this year with your assistance. There are probably a lot of questions, but this isn't the place for them; but if you have any, we are interested in having them. We have had to face some very bitter criticism. Your support and the support of the council as voiced by Dr. Shipman was most heartening to the members of the Blood Bank Commission. Just yesterday a worker in a national agency drawing blood said to me, "Dr. Jack, the only thing that is going to beat us is lack of money." I am hoping that we will show that we will win through with the most generous recommendation of the Council. That approval is most appreciated by the Blood Bank Commission.

There is one other point for the future. At the A.M.A. meeting in June we are going to set up a regular drawing center. We will have actual venipuncture performed. It will be an educational type of program. I hope you will see it. I hope that you will all see the little display we have created in the auditorium down at Balboa Park. I hope that you will go into the mobile unit.

One thing more. Don't let anyone in this group go away with the impression that you cannot have a blood bank if your territory needs it. The ones that have even a regional type of blood bank have it controlled, created by, directed by the men who use it, the doctors, and they have ten years of experience to go by. They don't have to start from scratch any more. There is no reason at all why we cannot this year and, in short, there is no reason at all why we cannot fulfill the promise we made to you in the creation of this commission two years ago. Then, at the end of the three years, we hope with your approval and support to give adequate blood coverage at cost to everyone who needs it in the state of California.

Thank you for your support. (Applause.)

VICE-SPEAKER CHARNOCK: The Committee on Industrial Health—Dr. Christopher Leggo. Is Dr. Leggo here? (No response.)

Committee on Rural Medical Service—Dr. Carroll B. Andrews.

DR. CARROLL B. ANDREWS: No additional report.

VICE-SPEAKER CHARNOCK: The next order of business is item number 18, constitutional amendments.

The chair will recognize Dr. Clifford Loos.

DR. H. CLIFFORD LOOS: Mr. Speaker, members of the house of delegates: To begin with, I want you to understand that the reference committee to which this measure has been referred has been an impartial one. It has worked diligently and hard. It has not tried to inject its own ideas at any time into these proposals. It has tried to be a mirror to reflect back to you the different impressions that have been impressed upon that mirror.

I wish to state that without the great assistance of Mr. Hassard, our attorney, we could not have functioned. Mr. Hassard never stepped out of character at any time. He has not injected his own ideas at any time. He merely answered questions and told us when we were getting off in legal phases.

The committee has heard several of you people who have ideas and I might say that I think it is perfectly within my province to state that I think it is with scant pleasure that we can realize how little attention we, as delegates, have given to this very important document. It has been in the file for two years. It was presented to you one year ago. Nobody began to think about it until about a month or so ago, until we began to get pretty excited over it. I cannot understand why we delegates didn't pay a little more attention to this before, instead of all

at the last minute. There is no reason for that seeming lack of interest. Perhaps we think we are delegates for two sessions, for Sunday and Tuesday, once a year. That is not true. We should function all of the time.

In going over the various points of the changes or the new constitution, I first want to state that a very fine job has been done by the committee in preparing this excellent document. Dr. Sam McClendon of San Diego has been chairman of this committee and there is every evidence of hard, diligent work. It is high time that we adopted some document of this type.

The committee to which this has been referred consists of Dr. Ivan Heron of San Francisco, Dr. Wesley Smith of San Diego and myself. We have had several meetings. There was a little preliminary meeting around the first of April in Los Angeles and we had one here last Saturday which many of you attended.

In going over the different points that were brought out and the different testimony that we heard and the different listening posts we have had from the north to the south, we have been led to the conclusion that there are some things that should be altered in this excellent document. I think you have the changes we have proposed.

I think we should leave that section of the new constitution alone regarding the selection of delegates. We felt, after hearing from some of our constituents, that instead of the limitation of one delegate to a county, there should be a minimum of two delegates. Some of the men in the smaller counties felt that they should have more than one delegate present. We felt, according to the testimony that we had heard, that the councilors should have the right to vote in the house of delegates.

One of the great controversial points in this document was the redistricting and that instead of 12 districts there should be 11. The reason for that is quite obvious, if you will go down through it the way this division was made. This is a hard state to divide. It is varied in its character, in its terrain, but I think the people in California are all the same.

When you have heard today that Contra Costa County and Alameda are going to merge their county societies, it seemed only right that Contra Costa County will be added to Alameda County and not kept as a separate councilor district. We felt that there should be 11 district councilors and that there should be six councilors-at-large elected by the house of delegates, the district councilors to be elected by their own districts. This, I know, is a controversial point which you will have to thrash out at your pleasure but that was imbedded in this change because of the testimony we have heard favoring councilors-at-large.

Also, it was felt by many that the size of the council should be changed. We feel if that is put into effect, with 11 district councilors and six councilors-at-large, it might give an undue advantage to Los Angeles County. So it is proposed that the vice-speaker be eliminated as a member of the council. In redistricting this you will note that District No. 10 is divided into Districts 6, 9 and 12.

Now that you have copies of this document you will have plenty of time to study it and discuss it later on. There has been a point brought up by many that the house of delegates should have some rights as to powers over the seating of councilors elected by the various districts. That is a controversial matter. We think we have hit upon a system where we can have that worked out and still not cause injury to anyone.

I want to read this Section 11, which is practically new.

"District Councilors shall be elected by vote of the Delegates from each district in the manner and at the time specified in the By-Laws; provided, however, that at the first meeting of the House of Delegates after a District Councilor has been selected, his name shall be submitted to the House by the Delegates from the district, and (1) if there is no challenge by any Delegate then the Speaker shall declare his election completed, and (2) if any Delegate shall challenge the election on any ground, including fitness of the nominee of the district to serve as a District Councilor, the questions presented by the challenge shall be submitted to a Qualifications Committee consisting of the President, President-elect and one Delegate, appointed by the Speaker, from the Councilor District involved. The Qualifications Committee shall consider all grounds upon which the nominee is challenged and report back to the House. If the Committee reports in favor of confirming the nominee's election, the Speaker shall declare him elected. If the Committee reports against confirming the nominee's election, a three-fourths affirmative vote shall be necessary to sustain the report of the Committee, in which event the nominee shall be ineligible to serve as the District Councilor and the Delegates from the district shall immediately proceed to the selection of another nominee for the vacant office. If an adverse report of the Qualifications Committee is not sustained then the nominee shall be declared elected by the Speaker."

There is an error in this section. I will read the section, calling your attention to the error.

"Councilors-at-Large shall be elected one by one from nominations made on the floor of the House of Delegates. Not more than two Councilors-at-Large shall be elected from any one 'county'."

It should read instead of "Councilor District." That will be corrected next Tuesday night.

A new section has been added or recommended added, reading as follows:

"Upon the adoption of this Constitution, the Councilors-at-Large holding office at the time of the adoption shall serve the remainder of their terms of office specified in the previous Constitution and as their terms expire successors shall be elected in the manner and for the terms provided in this Constitution."

The committee feels in view of the information it has received from various people that these changes should meet the requirements of all the

objections we have heard. The committee feels—in view of the necessity of making these changes as brought forth by testimony presented to the committee — and the committee recommends that the constitution as presented at the last meeting of the house of delegates be not voted favorably upon at this session. Thank you.

VICE-SPEAKER CHARNOCK: You have heard the report of the reference committee and the question is now open for discussion by the floor.

I think we will recognize first Dr. McClendon, the chairman of the committee who got together this constitution. We must be sure that each speaker will speak on the proposed constitution, the proposed instrument, which Dr. McClendon's committee is submitting, not the changes which Dr. Loos' committee has suggested.

DR. MCCLENDON: I have had considerable experience with this association and the A.M.A. and I will be very brief. I think that Clifford Loos and his committee have done a very grand job. I believe probably I have come forth with an acceptable formula which may be adopted by this house. However, if we present new ideas every year they will just have to lie on the table, as I would like to remind you that the substitute constitution and by-laws which Dr. Loos' committee has presented to you will have to lie on the table another year, and then probably at that time it will come up with some more objections, just as they have this time.

Frankly, your constitution and by-laws committee has worked two years on this thing in an attempt to do two or three simple things. They are simple and this matter that has been discussed tonight by Dr. Loos is not very much different than what we proposed in the beginning. First, we took out of the constitution those things which were needed in the by-laws, those things which can be changed easily and which may be subject to change readily.

Secondly, we in the State of California intended in our original constitution, 12 councilor districts. I can't see how you can divide 11 by three. That was in our original draft and it was also proposed that the councilors be elected by districts, by the delegates from the areas from which these councilors came, and we still think that is the thing that should be done. I still contend that is the best deal from a representative standpoint.

We propose that the delegates be elected by the members of the component societies, not in the manner that has been so prevalent in the past in various county societies, and that means all of you sitting here now. We all want the delegates to this association feeling they are of some importance and they cannot be selected in any other way. They are now being elected for different terms of office but the only change that was suggested in the present constitution as it was presented was that the council, in the expenditure of money, should, by a three-fourths majority, approve the expenditures beyond the budget. That is just a reasonable and business-like thing. After all, when your delegates are dealing with money of the type that we have and may have to spend, if and when an emergency should arise, certainly it would be only a fair safeguard to have at least three-fourths of the council approve that expenditure.

These are the three fundamental changes that were suggested. One of my friends and colleagues got up and waved a flag and said that if we continued under this proposed constitution, we would have communism, but that wouldn't be true; that we would be hamstrung in the expenditure of money, and that is not true.

If you will look at the old one and see all the little stickers stuck through here, you can realize and understand just what has been done. After all is said and done, my committee, and I would like to thank them again, as I did last year, has spent a whole year on this, 16 of us the first year and five or six of us the second year, meeting many times, a full day at a time. We have worked with the assistance of your legal counsel, Peart, Baraty & Hassard, and I can assure you if it had not been by request of this house that the constitution be rewritten, I wouldn't be standing up here trying to talk to you.

If you don't want it rewritten, it is okay with me. I do think that any of you who read over the whole constitution will recognize the necessity for streamlining this document and removing the amendments and amendments and amendments. Also, I would like to say here that if we continue to propose a new constitution, but not in criticism of some of the suggestions of Dr. Loos' committee, that the same thing is going to go on next year just as sure as I stand here tonight. It took us five years to get the constitution of the American Medical Association rewritten and it will take us more than ten years here. (Applause.)

VICE-SPEAKER CHARNOCK: Thank you, Dr. McClendon.

Further discussion is in order and we limit the discussion to the proposed new instrument, not the changes as outlined by Dr. Loos. Do we have anybody else who wishes to discuss this new constitution? Dr. Magoon.

DR. MAGOON (Santa Clara County): Is it in order that I use the podium, sir?

VICE-SPEAKER CHARNOCK: We want you to do so.

DR. MAGOON: I open these remarks with the unquestioned statement that I am in favor of the old constitution, the one recommended by the special committee. I am happy to add I was a member of the committee, the fruit of whose labor has been reported. Whatever may be the result therefrom in the way of bias, you may see for yourself.

First, the lesser virtues of the proposed constitution. If you have ever had occasion to seek a point in our existing constitution, you will agree with me, I think, that it is hopelessly disorganized, full of redundancies, inconsistent, and verbose to the point of frustration; if the proposed constitution corrects only this fault of the old, its adoption would save untold man-hours of labor and prevent the curdling of many otherwise sunny dispositions.

That the new does correct this fault in the old, I am sure you will concede, if you will but count the printed pages that each occupies. Besides being brief and concise the new constitution in a large measure more closely follows our desires in planning a constitution and the scheme of the organization, the goal of the association, outlining the broad and presumably permanent principles of the organization, and transferring to the by-laws those matters of operation and procedure whose details presumably might require at least occasional revision.

May I caution you therefore that you do not let a revision of the by-laws, with which you do not agree, color your thinking in considering this constitution. Technically the proposed by-laws are not even introduced. I believe that the revised version of the by-laws is ready for introduction and the reference committee will introduce other changes as a result of a hearing held yesterday. Even if those revisions still fail to meet your objects, may I point out the revision of the by-laws is comparatively easy and quick and I ask again that you make your decision on the constitution solely on the basis of its own merits and not of these subsidiary documents.

The hearing of the reference committee makes me believe that the only important controversial process of the new constitution is the organization of the council. I should like to discuss that subject at some length. I feel I am correct when I say that this original impetus resulted from a statement of the committee that drew up this proposed constitution and it was dissatisfied with the council as it is now organized. I refer you to the proponents of the original resolution to confirm what I say. On what was that dissatisfaction based? It was based on the belief that the council as now constituted is vested with full and complete power to commit the California Medical Association as it may see fit without any effective check or balance by any other authority within the association. In no other organization with which I am familiar, unless it be the hod carriers' union, do I know of an executive and quasi-legislative body which has such indefinite responsibility to its membership. That this power has been wisely and temperately used in the past begs the question.

The question then to which your committee seeks an answer, simply put, is this: How can we provide simple and effective changing over of the powers of the council without at the same time rendering its impetus ineffective? The answer seems to us to apply to the council the principle of representative government whose validity has been demonstrated by the 175-year history of the American government.

This would mean that each council member would have a constituency by whom he was chosen and to whom he was directly responsible. That to us meant that each councilor would be a district councilor and the councilor-at-large would be eliminated. That was accepted by both committees. The present constitution dictates that councilors-at-large come from the larger counties and districts, but there are counties from whom they are elected as a whole and not by districts from which they come.

It can be, and on occasions it has been, that the councilor-at-large is not the choice of a majority in that district. What support will this councilor receive and what sense of responsibility can that councilor have from his home county? Can anyone urge that such a situation is healthy, that it is for the benefit of the California Medical Association and that it does not entirely negate the principle of representative government? If we want representation in the council in the more populous areas, we had better watch this matter.

If, on the other hand, the councilors-at-large do represent the majority of the district, it is more consistent, more desirable and theoretically correct that they be elected as district councilors, that they be responsible to their districts directly and not filtered through the house as a whole.

I have been told in the past that councilors have never disagreed on the basis of north versus south or urban versus rural. That is a happy situation and there is no reason why it should not continue. To my mind there is no basic difference in the interest of the doctors. There should be no difference of opinion held by the doctors in the cow counties and the doctors buried in a metropolitan center.

The object of the committee in providing for geographical organization of the council was not to balance voting power but to assure that every member of the association would have a representative on the council whom he considers his own and whose responsibility to him was dictated only by the delegation of his own district and not by that of the whole state. That was the check on the council, the application of which is believed necessary and one to which no fair-minded councilors should object.

That leads to another point on the basis of the information originally told to the committee at the time when a small council seemed desirable. It now seems that the committee work of each councilor has attained a greater speed. It would not invalidate the principle of representative government and it would not be inconsistent with our thesis, and I have become convinced it would be in the best interests of the association, if the size of the council were increased. I would therefore suggest an amendment that provision be made to increase the district councilors for three or four of the larger councilor districts. I would also propose that in spite of the sparseness of the medical population but because of the tremendous geographical areas involved, the two northern districts be split so that we have two new districts, one centering around, say, Eureka, and one around, say, Redding. If these be created, this would result in a council of adequate workable size.

I have said that these changes should be accomplished by an amendment of the proposed constitution. I am wholly opposed to further delay in the adoption of the new constitution and I am sure that the council will carry the load for a year until its

membership can be increased in the manner I have described.

One more point. I have heard it said as an argument against the proposed constitution that the present council should not summarily be dismissed in entirety until the new council is chosen, but examine this argument more closely. Admittedly, some of the old council members will be out of office as this redistricting will cause some changes, but otherwise it seems to me that the present council, which is well represented from the districts and efficiently doing its job, should certainly be re-elected. Does anyone wonder that a councilor who does not meet this criterion, who does not command the support of the majority of the delegates from his own district, should not be continued in office? I will be glad to explain what I believe to be the obvious answer.

In summary and in conclusion, may I say that I feel, frankly, that the merits of the proposed constitution far outweigh any demerits that it might have and I believe that it will bring to the California Medical Association true and valid principles of representative government whose application is long overdue.

I respectfully solicit your support for its adoption. (Applause.)

VICE-SPEAKER CHARNOCK: We will continue the discussion. Dr. Caldwell.

DR. CALDWELL: Mr. Speaker, members of the house of delegates: This constitution is not a perfect instrument but Dr. McClendon has told you it represents the intention and efforts of some of the finest minds in the state of California for the past two years. If this constitution were perfect we wouldn't have set machinery in motion for amending it.

Dr. Loos' committee, as others of you, believe that it should be amended. I agree but I believe, first, that it should be adopted and then amended. We can live with this thing but we must not forget one thing. My understanding is that it is proposed to amend it this year, then again next year and the year thereafter until we will not get a streamlined workable constitution. For those of you who are lucky enough to be delegates and lucky enough to be alive, you will be attending the sessions in wheelchairs and still working on this constitution.

I would like to mention a couple of things that have come to my mind which stand out in the new constitution, the new proposed constitution. One is direct election of councilors. It is proposed that by secret ballot the delegation will be elected by members of the county medical societies. Now, that, to me is the only truly representative way and the American way. Also, it abolishes the councilors-at-large. This, as you know, is the situation where a councilor living and having his office in one county represents and is elected by the state as a whole and represents the state as a whole. We are told that a councilor is supposed to visit the district at least twice a year. If the councilor-at-large had to visit each county twice a year, I don't think there would be so much competition for the office.

In the old constitution there are a few words which I think bear mentioning. They are "promote the betterment of the medical profession." I think it is about time that we begin to forget personal ambitions and begin to forget fancy loyalties to certain political groups and begin to think of the good of the entire membership of the California Medical Association. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Cline.

DR. CLINE: Mr. Speaker, members of the house: I think I have no fanciful loyalties to any particular group. I served on the council of the California Medical Association for a period of about ten years.

If you adopt this instrument, you are going to change the whole plan of the organization of the California Medical Association. This house of delegates is chosen by the constituent county societies throughout the state. This is a truly representative body which gives the representation which certain speakers have implied as inherent in the American system.

DR. RICHARD O. BULLIS: A point of order.

VICE-SPEAKER CHARNOCK: Will you state your point of order?

DR. BULLIS: The gentleman speaking is not a delegate or a member of the house. He is speaking without permission of the house.

VICE-SPEAKER CHARNOCK: We will ask for permission of the house so that Dr. Cline may speak. Those in favor of Dr. Cline speaking will say "aye" and those opposed "no".

. . . A vote was taken with the "ayes" in the majority. . . .

VICE-SPEAKER CHARNOCK: Dr. Cline will be allowed to speak.

DR. CLINE: Thank you, Mr. Speaker.

The members choose their own delegates and these delegates simply carry out the wishes of their own constituents. The council has an entirely different function. The council does not expect, instead of the house of delegates and on behalf of the house of delegates and between meetings of the house of delegates to determine matters of policy. It is primarily an administrative body. It conducts the business of the association. One speaker said that he knew of no other organization in which such powers were vested in a comparatively small number of the membership but he never read the constitution of the American Medical Association. Their power and that of the board of trustees exceeds those of the council of the California Medical Association.

It also happens to have been my experience, being a member of the council and being chairman of the executive committee in the hectic days of 1945, 1946, and 1947, that we found many times when actions must be taken immediately. The house of delegates cannot be assembled. The council cannot be polled immediately to obtain a three-quarters vote. Such things would have to be explained, such details as

were incurred. They would have to be explained very carefully under these circumstances to all of the members of the council. Then we would have to have the three-quarters vote to exceed any budgetary provision that the house would make. If you don't trust your council, if you don't trust the people that you elect to conduct the business of this association in an emergency, then my thought is that it is not the system which is at fault but rather the personnel.

I would also sketch the history because I am intimately familiar, as was shown here, that this whole idea of the constitution such as now proposed here, arose not out of the efforts to improve the instrument of the association but rather out of dissatisfaction with the then current personnel of which I was a member. I, therefore, realize that this, in order to pass, must take two years and that we now have an entirely different construction to place on it.

I think there is another serious defect. You have heard the councilors-at-large assailed. If you will recall, and I think I am correct, that Dr. McClendon was a councilor-at-large, Dr. Sidney Shipman, the present chairman of your council, is a councilor-at-large, Dr. Ed Bruck, your recently presiding chairman of the council, was a councilor-at-large. I could go on indefinitely mentioning the valuable men that the association has had, the men who really have carried on the work, and they have been councilors-at-large. If you eliminate the councilors-at-large you would eliminate immediately some of the most important people whom you have serving you, possibly replacing them with equally competent individuals.

There is another thing I would like to speak about. That is that this instrument also proposes to reduce the size of the house of delegates. For the past year and a half I have been intimately associated with the idea in an effort to educate doctors to their responsibilities, to their profession, and to get them to do a real and realistic job in the protection of America.

DR. MAGOON: May I at this time rise to a point of order?

VICE-SPEAKER CHARNOCK: State your point.

DR. MAGOON: This gentleman is not speaking on the constitution but the by-laws, sir; not the constitution.

DR. CLINE: I stand corrected.

VICE-SPEAKER CHARNOCK: Will you keep then to the constitution and discuss it only. That is what we have before you.

DR. CLINE: I shall try to, sir.

I shall simply make one other comment with reference to my ideas and that is this: That the larger number of people who would be intelligently acquainted with the business of this association, the better it is going to be, the greater is going to be our strength and the better the functions of the California Medical Association. Thank you. (Applause.)

VICE-SPEAKER CHARNOCK: Is there anyone else who would like to discuss this subject?

DR. MARDEN A. ALSBERGE (Los Angeles): I agree with the previous speaker, that the new constitution would make some radical changes in the way that the body is organized and the way this body is functioning. I am one of the individuals that believe a few radical changes are necessary. I believe that the councilors are a vital necessity in this organization. I believe that the delegates should be elected by their own constituents. I do not believe that it is possible to have proper representation without responsibility and if the men are not responsible solely to their own counties direct, they do not have that responsibility. I have heard that the council has found it necessary to act at times, in the absence of a meeting of the house of delegates, in certain emergencies. That is certainly true and that will continue to be true but certainly I believe that it is necessary to curb considerably the powers of the council.

I wish to cite one example. On this floor, gentlemen, just a year ago, there was a resolution presented in the meeting of California Physicians' Service. The resolution to which I refer was a 50 per cent reduction in the radiological fees. To be very brief, it was the first time in my memory that there has ever been brought up a discussion on such a proposition so controversial as this has been and which so unanimously expressed the will of the gentlemen seated here tonight. After three calls from speakers, there was not even a second.

However, the council found it necessary this last year to approve in principle, according to the minutes of the association, not only this fee schedule but, coming under this bracket also, the pathologists, approving in principle the setting up of a committee to sample the work done by the physician participating member as to whether or not his work was adequate and satisfactory. This I do not believe was an emergency, an emergency that arose at the moment. I believe that this situation could partially be correct and I cite you this one example. There are others. I believe the situation could not arise quite as readily if the council members were responsible to the men who elect them.

I believe that every councilor district has the right to say who will represent them and I believe that that councilor district has the right to hold that man accountable when he returns to his district. It is not possible for this state of California, the medical association, the whole councilors-at-large, to be responsible for anything when the councilor returns to his district to report and that represents but a small portion of the whole.

The main question, it seems to me, is to decide whether or not we need a new constitution. A lot think we do and a lot think we don't. If we do determine that a new constitution is necessary, we must at some time in presenting a new constitution, take action. There will be many delegates who will wish to appear before Dr. Loos' committee. Every day there are men and groups of individuals, I being one, who definitely and irrevocably would object to certain portions of the new constitution or the sug-

gested constitution. I am opposed to several phases of it but I will put up with it until they are changed. However, with as many matters as there are to the new constitution and with a group of 50, possibly, here opposing it and the group of ten over here opposing it and another group of 15 here opposing it, it seems that the total opposition to the constitution is overwhelming. Then, if we pass it on to another year, then this body changes by about 50 per cent. The new crop has new ideas and new changes.

First we must adopt a constitution. Then, if necessary, later, and I believe it will be necessary—every speaker has suggested that it will be necessary—we can change it. If we don't adopt the new constitution tonight, we can suggest additional amendments to the present constitution and they can lay over and be adopted next year, just as you would hold the whole constitution over with the suggested changes of the reference committees, and they can be adopted just as quickly; yet we will have a constitution but we will wait until next year when members of the house of delegates will make new objections. This in turn will hold it over for another year and this will go on continually, indefinitely, gentlemen, for years, but if we are going to have to get our feet wet, I suggest and propose we get them wet tonight. (Applause.)

VICE-SPEAKER CHARNOCK: Is there anyone that wants to discuss this important matter further?

DR. WESLEY S. SMITH (San Diego): I have been listening to the very interesting observations and in this very short time when I am on my feet, I wish to say that most of the speakers that have objected to the rejection of the constitution, as printed in the December journal, have closed the issue by getting over on to the by-laws consideration rather than sticking principally to the constitution.

Your committee has listened long and hard to many objections to the constitution as printed in last December's journal. I want to remind those that have spoken so far tonight that none of them has given credit to the fact that the committee that studied the constitutional changes reported it to this body too late for open discussion or for those to attend that reference committee and discuss these changes; therefore, the statement that next year we will have to make more changes and then more changes is not based on fact. The fact is that this body tonight is the first one that has had any opportunity to criticize this constitution other than the committee itself.

I believe there is a final fact that we shouldn't overlook. I think that Dr. Cline made some very fine suggestions and I think it should completely negate the suggestion that the councilors-at-large do not represent either their constituents or the state, for I should like to add a few more: Francis West from San Diego; Ben Frees from Los Angeles; Gordon MacLean from Oakland and C. V. Thompson from Lodi, and those of you who are experienced know that no matter how far back you go that your best men on the council have been councilors-at-large. The councilors-at-large have been a safety factor and we must realize that there never has been very much difficulty when we have had changes in growth in the state and if anybody here wants to predict where that is going to be ten years from now, let him. I am not much of a prophet, but there are going to have to be certain changes.

I would like to make one further point. I should like to see this controversial point regarding the council put over but I guess it is legally impossible as the council is the basic controlling body of our organization. That answers the point that the controversial points were put into it by law. It cannot be done as far as the council is concerned. I think the fact that we are interested in, and on which I think we are entitled to some discussion, and I believe the record will show a year from now that with the changes that your reference committee has suggested which are based on the oppositions of the people appearing before them, the bugs will be pretty well ironed out.

I would like to adopt the constitution Tuesday night and which on Tuesday night will have had five amendments made to it, and, in all probability some more, and so that next year, if somebody has a copy of the constitution, you will open it up and see on page after page little pieces stuck on it and no one can find their place. So let's make a new one from tonight. I think we are all a little bit confused tonight. I think we shall make a very grave error in our confusion, because this is our first time to criticize the instrument.

The committee did a fine job. There is nothing changed except to adjust, in effect, questions which were considered, in part, based on the Contra Costa combination with Alameda; partly because it leaves a district which is not laid out right and partly because there is an objection, which is objected strenuously, to the way the council has laid out two sections in the city and county. This leaves it up to them to make their own decision. The other change is that some small community would be deprived of an extra delegate. These all seem reasonable to our committee. That is why I should like again to suggest that if you want to adopt the present constitution, then go ahead and amend and amend and this session will still lay it over for a year. We felt it was better to reject the present constitution but use it as a principal guide to make these other changes which can be done now, laid on the table a year and then you will have a useful document.

Thank you very much. (Applause.)

VICE-SPEAKER CHARNOCK: The chair will recognize Dr. Remmen.

DR. E. T. REMMEN (Los Angeles): Mr. Speaker and members of the house: I had thought of talking about an hour tonight on this subject and including a few stories but time is very short, so I will omit all of that.

It was my privilege to serve on the first committee which worked on this revision. The committee was a representative group which came from all over the state. They worked very long and very hard on it. The committee tried to reconcile the rights of

the large congested districts and the sparse rural districts by selecting the council on a geographical basis and the delegates on the basis of population. I think that is done very equitably, as equitably as possible, in the new constitution as proposed. It probably was not dissimilar to that which confronted the founders of this country who had likewise to adopt a system of government which was fair to New York City and to the remote wilds of the less densely populated colonies.

I was rather amused at the statement that our best councilors have been councilors-at-large. That is unusual in view of the fact that there are so many more district councilors and the fact that they have all been elected in the same way by the house of delegates. I wish I had time to tell you some of the things that went through the minds of the committee that worked on this matter. It went through my mind and I have no doubt through the minds of some of the others.

The reasons for reducing the house of delegates were several. One, the possibility we would, because of the press of business, come to two sessions of the house of delegates a year. The second session would possibly not be a convention and it would only be natural that the California Medical Association would defray the expenses of the house.

DR. MAGOON: I again rise to a point of order.

DR. REMMEN: I am sorry. That does relate to the by-laws.

There is one thing we all remember. While the house of delegates, including many men with experience, voted for compulsory health insurance, I don't think that our council, during the 15 years or 20 of my acquaintance with it, has been entirely infallible. My mind goes back to the survey of the state that determined whether we needed some form of health insurance which was conducted by Professor Dodd of the University of California at Los Angeles. Then you know about that $50,000 or $60,000 survey for which we paid, which was used against us. I am sure you all remember the Foote, Cone & Belding outlay, another very extravagant expenditure, which this council, which has never made any errors, carried on, in order to find out whether the people like us and what they thought about us. We know what they thought about us; we know how they liked us but they didn't like our fees. We didn't need that survey to tell us that. We then got our survey and as a development of that we went out and hired a public relations firm and we hear continually of what a wonderful job they are doing. I hope they are.

From a practical standpoint, however, may I remind you that four years ago here in California we had indemnity for illness added to the unemployment insurance law. Two years ago we became the first state to have hospital insurance added to it and we will probably, if we aren't very fortunate, have indemnity for medical care added to it in this state where, through publicity, we have kept government medicine out.

Now, let's be practical about it. That is the present situation of California. We are the nearest to any state to have the whole bill and on the strength of that we went back and sold our public relations firm through their work to the A.M.A. That is all I want to say on that. This council that represents the carefully considered thought of a large group of men, who have not been desirous of holding office, did the best they could with the thing. If it is wrong in a few places, if it doesn't suit everybody, I think the simplest thing is to say that we have a constitution which already needs revising. Why, the Lord himself couldn't write a constitution that would suit everyone. It will probably be necessary to amend the old one but with this constitution we can start afresh and then if you want to amend it next year, you can. At least it is something of a modern and a scientific constitution. I hope you will adopt it. (Applause.)

DR. JOHN W. GREEN: Mr. Speaker and members of the house: I have served about ten years on this council that you are finding fault with—very sorry. I have done the best I could with the tools I had. However, I don't want to apologize so much as to point out to anyone of the organization, as a member of the council, that my idea of the councilor-at-large is this: They have been the balance wheel of our council and the many acrimonious disputes which we have had which were dealing with local problems — they might be dealing with San Diego, they might be dealing with Sacramento and they might be dealing with some other locale—and, naturally, the councilor representing that district is going to present the ideas of his constituents. That is what he has been elected for—to represent them and carry their ideas to the council.

Sometimes he had a pretty good battle on his hands. It sometimes gets pretty tough and I have seen it get awfully tough about four times. In every instance, if my memory serves me right, the councilor-at-large was the man who was broad enough to do what was good for medicine in California.

We have had threats of secession. Nothing happened. Why? It was because we had a pretty good council. Otherwise this might have happened.

I would also like to say this about the right to vote and I don't believe this is in the by-laws. I don't believe you can ask any councilor to serve you for three years and then reelect him to serve you for three years more. He gives up his business. He has fights with his wife. He does everything that is bad for him, to serve you, and still, in spite of all that, this new constitution recommends that he will have no vote on the floor of this house. I don't believe that is just exactly what you gentlemen would like to have your councilors do. I can't believe it but it may be so. Maybe it wasn't properly discussed.

I do want to say in closing that Clifford Loos did a good job in the spot that he had—you didn't like it, I know, but it was advertised, at least to me, that that meeting would be held at the time specified. Everybody, I think, had just as much chance as I had to go there and express his views and I hope you do not accept this constitution, because, if you

do, you accept it in toto and there is nothing in there, in accepting it, that you will amend. (Applause.)

VICE-SPEAKER CHARNOCK: Is there any more discussion?

DR. ASKEY (Los Angeles): Mr. Speaker, members of the house of delegates: Somebody said one time that the only ones that the American people have any confidence in at all are those they are about to elect. After he is elected everybody shoots at him.

Now, it doesn't seem to me that we have any reason to go back and say whether Sid Shipman or whether I or anybody else was a good councilor at the time they were on the council. They did the best they could. Maybe we didn't like it. Maybe they made mistakes. That is not the point at issue now. The point at issue is this: There is a proposed new constitution before us which is detailed and cannot be changed at this time by one single semicolon, period or comma. If you adopt it, you adopt it as is and it will then be your constitution. It will change the whole set-up of the California Medical Association and everything that is now being done is wrong. The people who will be the new council will immediately have to be elected and you will have to get a whole new crowd. It may be that you will elect some of the boys that have been in if you still have confidence in them but you are going to have to set up a whole new set of things at this session of your house of delegates. If you adopt it, from that minute tonight everything else is out.

Everyone that I have heard speaking tonight agrees that there are changes in this proposed constitution that must be made. It wouldn't be right to follow it and go by it until these changes were made. Now, if these changes are not made, you are then going to go for a whole year on a procedure which may upset everything that we are trying to do. There will immediately be jostling for positions; there will be those who are working for this and that and this session at Coronado will end up in the greatest turmoil that you ever saw.

If we have to have amendments I believe that they should be right. I agree that the other constitution could be well changed. It seems to me that you have had a committee studying this thing and looking at it from all angles and what does this committee say? It comes in and says, "We believe that there are certain good points in the proposed constitution but there are lots of others that are very, very bad and therefore we think that it should be changed."

Now, gentlemen, which would be better, to continue with the troubles which we have and which we understand but which we can change, and we intend to change, or to put on our books not only the troubles which we already have but all the rest of them that will come in addition? It seems to me that it would be very wise to continue with our old constitution and have this committee which recommended the changes which they want, introduce them at this time to be considered and put into effect next time.

You are going to have the same thing done if you adopt the new constitution and you are going to have so many troubles on your hands that nobody will know where we are. I cannot see in my own mind how I or you can give the balanced thought to this at this short meeting tonight that Cliff and his committee have given to it. In my opinion, they saw the best thing to do and that was to recommend at this time to reject the proposed constitution and, instead, take this proposal and then you have something that you can build on. It is conceded that you have some troubles, but we can understand the troubles that we know. The troubles that are going to bother us are the ones that will inevitably pile up on us with new changes and I therefore hope that you will reject this and ask your committee to introduce your amendments which they think will solve the problems. Then let us, if you wish, have this committee as a special committee, to study this and have hearings during the year on this and then, when we come back next year, we won't sit here cold turkey but we will have the additional reports which they will have at that time.

I sincerely hope—and I have no axe to grind any more—you have given me every honor in this association, most of which I didn't deserve, but which I feel very humble for—if you believe my advice is worth anything, and you simply believe it or you don't believe it—that is up to you—but my advice is to reject this proposed constitution and go at it in the right way. (Applause.)

VICE-SPEAKER CHARNOCK: I want to give everybody an opportunity to be heard. Dr. Bullis from Los Angeles County.

DR. BULLIS: It seems to me the question before the house tonight is whether you wish to accept the suggestion and recommendation of the two committees, one for a period of two years' hard work, a committee of 12 or 15 men, and one committee of five, or whether you wish to set that judgment aside and accept the recommendation of the committee of three who have worked for a period of a few days. The chairman of that committee had not even read the constitution, I believe, until he was appointed chairman of the committee. I think that it stands to reason that the work done by the two committees—unfortunately, I happened to be on the last one—but I think that the committees working with the same legal advice would be better to follow than the one committee in a short time. I respectfully urge that the new constitution be adopted and any variations that may be needed could be proposed and laid over for a year.

VICE-SPEAKER CHARNOCK: Does anyone else wish to speak to this?

DR. WILLIAM G. DONALD (Alameda County): Mr. Speaker: I would like to say a few things because I was on the committee of the original 15 men and, after listening to the debate here tonight, several curious things have come to mind. This committee on the proposed new constitution was obey-

ing the house of delegates mandate that the constitution of the council be changed. That is at your suggestion and demands. I have been very interested for two years in this constitution and during the past month, since it has been published and studied by quite a number of members of the house of delegates, I find no one criticizing the omission of the council but those who are councilors or who have been councilors.

I regret that Dr. Cline has put this on a personal basis, aiming at individual councilors. No such thought was in the mind of the delegates when they asked that the formation of the council be changed. It wasn't a personal matter. Councilors have been invariably leaders of our society and great men. There is no reason in the world why they shouldn't still be the same councilors.

These committees of 15 and five, then, have studied this thoroughly with your demands in mind and have brought forth this constitution. Your reference committee has not even studied it two days. The speakers in general here have not given it as much thought as the original committee acting at your behest. If opinions are to be considered, I certainly would consider the 20 men who have studied it for two years far ahead of those off-the-cuff opinions and I would urge you to accept the constitution as proposed in toto. (Applause.)

VICE-SPEAKER CHARNOCK: Does anyone else wish to discuss this instrument before we vote on it?

DR. J. E. YOUNG (Fresno County): I did work on this committee but there is no reason why, after new information is obtained, that opinions cannot be changed. You have discussed the government of the California Medical Association to great extent. It has been very interesting but it would also be very interesting to look into the proposed constitution and see what it would do to you as individuals.

This morning I learned a very good objective lesson on the value of time and on the value of money. Time is of no essence in this thing if we can do it right. Let us take ten years and certainly if it is going to be fool-proof, it surely is going to require repeated amendments. Let us amend the old constitution step by step.

I would refer you specifically to Article IV of the proposed constitution, Section 4, heading of "Funds, Property, Dues, Assessments and Expenditures." This section provides means by which C.M.A. may raise funds. It provides that the house of delegates may levy special assessments in addition to the regular dues upon membership of the C.M.A. It provides also that the house of delegates may levy penalties upon members and even assessments. It also provides penalties for failure to pay the assessment or surrender of membership in the association or component society or both.

I come here tonight as a representative of my society and my society is very jealous of its rights and prerogatives. I am very certain that my society would not agree to me, as their representative, in this house of delegates, giving you the right to suspend membership in the local society. Suspension of membership in the local society is a very serious proposition. I am certain that we on the local level are much better qualified to determine qualifications of membership than you in this house and I fear that in the future, if you adopt this constitution that you may use this right very poorly and very arbitrarily.

There is the danger in this proposed constitution that your rights as a member in the local society can be abrogated for other things because it has been the history of people down through the ages that, regardless of what the motives have been, the attending powers have always wanted more power and they have taken it. That is the reason why in our own national Constitution in the Convention of 1789, regardless of the time it took to adopt it, and regardless of the time it took to amend it, and constitutional conventions were held in various states, that Constitution was rejected and sent back and they said, "We will not take it until you provide us with specific and well written recommendations as a guarantee of our rights." That came to be known as the Bill of Rights upon which we base our own separate individual rights.

This proposed constitution in no way guarantees us the right of individual membership in the local society. Furthermore, if this house some time in the future sees fit to levy an assessment upon the membership, when the budget has been exceeded for some reason, I know of no better way in which this house can receive a vote of confidence than it can by a failure to accomplish the payment of that assessment. Certainly there could be no better vote of confidence of any action of this house than to take this action and I do not propose to be browbeaten in any way by voting "no" against any assessment of this house now and if I vote "no" upon an assessment of this house, the membership in my local society is in danger and thus my livelihood is in danger, so I hope that you will think long enough to reject this constitution in whole. (Applause.)

DR. REMMEN: I rise to a point of information. Is it not a fact that at the present time the constitution provides that membership in the national, state and county medical associations is inseparable and the loss of any one is a loss of all three?

VICE-SPEAKER CHARNOCK: As far as I know, that is not so, Dr. Remmen. It starts at the county level first.

Does anyone want to discuss this any further? Is there any more discussion?

DR. ROBERTSON WARD (San Francisco): As a member of the committee of five that brought this proposal to you, I want to admit fallibility. The argument has been made here tonight that certainly you should put your trust in the 20 men who have considered this thing over a period of years to a greater extent than you should put it in the committee, the reference committee, that has been appointed to serve for a month. As a member of the committee of the 20 people who have considered this over a period of two years, and as a member of

the committee of five that made the final draft, I would like to urge the rejection of the constitution because it is inadequate in my point of view. (Applause.)

VICE-SPEAKER CHARNOCK: Does anyone else want to discuss this?

. . . The question was called for. . . .

VICE-SPEAKER CHARNOCK: The question has been called for. We are going to vote on this constitution as a single instrument, the constitution as printed in CALIFORNIA MEDICINE for December and in the Reports Bulletin. Are you ready for the question?

A MEMBER: If you vote "no," do you reject it and if you vote "yes," do we reject it or what?

VICE-SPEAKER CHARNOCK: We are going to vote on the constitution itself and not on the report of the resolutions committee. I think if we vote for this either "yes" or "no," it will be much simpler for us to understand what we are voting for.

DR. MAGOON: This was presented to the house last year for decision tonight and you can't change it. It has got to be voted on as a constitution.

VICE-SPEAKER CHARNOCK: We are going to vote by ballot and I see no reason why we cannot vote either "yes" or "no" on the constitution itself and not on the recommendations of the resolutions committee. Are we all clear on that?

A MEMBER: Does "yes" mean you accept it and "no" you reject it?

VICE-SPEAKER CHARNOCK: Yes, that means we accept the new instrument if we vote "yes" and "no" means we reject it. Is everybody clear on that? Is the house willing to vote by ballot?

. . . There were cries of "yes." . . .

VICE-SPEAKER CHARNOCK: All right, we will appoint Dr. Bullis, Dr. Ward and Dr. Sam Randall as tellers.

DR. REMMEN: A point of order.

VICE-SPEAKER CHARNOCK: Do you want to state your point of order?

DR. REMMEN: We are voting on the new constitution and has the roll been called? Is there a quorum of the delegates present here?

VICE-SPEAKER CHARNOCK: The house was constituted at the outset when the report of the credentials committee was given. There was a quorum present and at the present time there is a quorum present. The only people who will vote will be the delegates. Will our legal counsel give us any advice on that?

MR. HASSARD: Mr. Speaker: The only persons who may vote are those who are seated as delegates and who reported as such to the credentials committee earlier this evening. For the information of the house may I point out that the vote, in order to adopt the new constitution, must be a two-thirds affirmative vote. That means when you cast your ballot "yes" you are voting in favor of the adoption of the constitution as was presented a year ago by Dr. McClendon and if you vote "no" you are voting for rejection of it.

A MEMBER: I question that the chair can accept that vote. I believe we have to call the roll and that the alternates for absent delegates must be seated.

VICE-SPEAKER CHARNOCK: A request has been made for a roll call. That is in order.

DR. REMMEN: In the interest of saving time, would I be in order in suggesting that the vote on this question be taken on Tuesday when the house has been polled?

VICE-SPEAKER CHARNOCK: I don't think you can do that. I think we have to vote on this tonight and have it either "yes" or "no." The roll will be called. Will the secretary of each delegation be prepared to put in an alternate in alphabetical order.

. . . The roll was called by the secretary, Dr. Garland. . . .

VICE-SPEAKER CHARNOCK: The tellers will please come forward, Dr. Bullis, Dr. Ward and Dr. Sam Randall. We will now vote on the ballots. Those who have been seated as delegates will have the right to vote accordingly and the ballots will be passed out.

. . . The ballots were then passed to the delegates. . . .

VICE-SPEAKER CHARNOCK: While they are passing the ballots and while they are voting upon them, we will state again that you will vote "yes" if you are in favor of the new constitution and "no" if you are opposed to it. While we are passing the ballots we will proceed with the next item of business which is new business, No. 19, the introduction of resolutions. Those who wish to present resolutions will come forward and state their name and their county and have their copies ready to be handed to the secretary.

Resolution No. 1

(Previously introduced as addendum to report of the council.)

DR. GERSON R. BISKIND (San Francisco): The San Francisco delegation has instructed me to introduce the following resolution. I will omit for brevity most of the "whereases." I will just read the "resolved."

. . . The complete resolution is as follows . . .

Resolution No. 2

WHEREAS, The closed panel system of distribution of workmen's compensation medical practice is alien to the principle of free choice of physicians and may result in unhealthy regimentation, and

WHEREAS, The California State Compensation Insurance Fund has had a modified open panel for more than ten years, and

WHEREAS, Certain private compensation insurance companies are experimenting with modified open panels, and,

WHEREAS, The medical profession of the State of California is exceedingly capable and able to give the best care to injured workmen on a modified open panel designed to give considerable choice of physicians, and

WHEREAS, Free choice of physicians fosters an improved patient-doctor relationship, an essential

often lacking in the rehabilitation of the injured workman when he is treated under the strict closed panel system; therefore, be it

Resolved, That the house of delegates of the California Medical Association approve the principle of an open panel in the practice of workmen's compensation cases; and be it further

Resolved, That the council of the California Medical Association be instructed to use all power within its means to foster the use of open panels in the practice of workmen's compensation insurance; and be it further

Resolved, That the council of the California Medical Association be instructed to set up a committee to study open panel compensation insurance practice with the view of working out some of the problems presented by the medical profession, insurance carriers, and/or self-insured employers, and organized labor.

DR. MAGOON: May I rise to a point of order?

VICE-SPEAKER CHARNOCK: State your point of order.

DR. MAGOON: It is 12:00 o'clock. There is a tremendous volume of resolutions to be introduced. Would it be in order, since the resolutions are to be published and presented to the reference committee, to present them to this house by title only?

VICE-SPEAKER CHARNOCK: If the house wishes, that may be done. What is the wish of the house? Those who wish the resolutions to be presented by title only and not read will indicate by saying "aye" and those who wish to have them read will say "no."

. . . A vote was taken on the suggestion and the majority voted "aye." . . .

VICE-SPEAKER CHARNOCK: The motion wins and they will be presented by title.

DR. BISKIND: Most of these resolutions are not formally titled but I will try to describe them.

. . . Dr. Biskind presented the following resolutions . . .

Resolution No. 3

Resolved, That as a statement of policy the California Society of Pathologists is opposed to the centralization of facilities for the initial diagnosis of malignant disease by means of examinations of tissues, exudates or bodily excretions by whatever name the procedure might be called. This is specifically meant to include any exfoliative cytologic diagnostic procedure proposed as a part of any mass survey conducted by federal, state or municipal government or political subdivision thereof or by any private organization sponsored or supported by such governmental agency or by endowments or public voluntary contributions; and be it further

Resolved, That exfoliative cytologic examinations incident to mass surveys be done at the local level by pathologists licensed to practice medicine in California. Should the local pathologist desire consultation, in accordance with the usual custom he may refer the material to any pathologist of his choice.

Resolution No. 4

WHEREAS, The subject of industrial accident fees is of considerable interest to all members of the California Medical Association, and

WHEREAS, Every member should have an opportunity to study and to voice his approval of any fee schedule which he is required to support; be it therefore

Resolved, That any future proposed fee schedule be placed before the component county medical societies and all interested and recognized specialty associations for their study, comment and approval at least sixty days prior to submission to the Industrial Accident Commission for its final action.

Resolution No. 5

WHEREAS, The physicians of California have been experimenting in the distribution of the cost of medical care through California Physicians' Service for more than ten years, and

WHEREAS, The California Physicians' Service has never paid 100 per cent on its fee schedule, and,

WHEREAS, It is the duty of the California Medical Association to point out to the public the real cost of standard medical care, and

WHEREAS, It is unwise for the profession to be engaging voluntarily in any business practices on a small scale that would be dangerous or impossible if the same were put into universal practice or brought under Government control; now, therefore, be it

Resolved, That the house of delegates of the California Medical Association request the board of trustees of the California Physicians' Service immediately to make it a policy that all new and renewed contracts written shall have sufficient premium to fulfill actuarial requirements to pay 100 per cent on the fee schedule.

Resolution No. 6

WHEREAS, The present practice in force in California Physicians' Service provides for the payment of professional members at a rate representing less than that of its present established fee schedule, roughly 80 per cent; and

WHEREAS, This aforementioned fee schedule, even though paid in full, is insufficient to reimburse its professional members for operating expenses and a reasonable profit; and

WHEREAS, California Physicians' Service has now announced that it is embarking on a new venture, a catastrophic illness plan to cover 23 chronic illnesses; and

WHEREAS, This new coverage is to be paid from funds separately assessed for this specific coverage; now, therefore, be it

Resolved, That the council of the California Medical Association be instructed by this body to demand that the premium for this new coverage be set at a level which will insure that professional members be reimbursed at a rate representing 100 per cent of the established fee schedule.

Resolution No. 7

WHEREAS, The subject of medical service and hospital service corporations is of vital interest to the people of California, especially the medical profession; now, therefore, be it

Resolved, That the house of delegates of the California Medical Association instruct the council of the California Medical Association to make a thorough study of all possible government regulations of hospital service and medical service corporations, open panel, closed panel, mutual, non-profit, and profit, so that any time legislative action in this field is imminent a program to defend the rights of the people of California and good medicine will be at hand and some emergency expediency will not have to be used.

Resolution No. 8

WHEREAS, There are many indemnifying insurance policies for medical and surgical benefits in the State of California, and

WHEREAS, Indemnifying insurance for medical costs does not regiment practice and offers free choice of physicians, and

WHEREAS, Indemnifying insurance does not fix medical fees, but leaves that to the physician and patients, and,

WHEREAS, Medical guidance is being sought in the field of indemnifying schedules for medical costs; now, therefore, be it

Resolved, That the house of delegates of the California Medical Association approve voluntary indemnifying insurance as a sound and excellent method of distributing medical and surgical costs; and, be it further

Resolved, That the council of the California Medical Association be instructed to inform, and/or advertise to the public that the California Medical Association approves the indemnifying insurance as a method of providing the cost of medical and hospital expense; and, be it further

Resolved, That the council of the California Medical Association be instructed to institute a thorough study of indemnifying insurance for the purpose of pointing out abuses that can be eliminated by the medical profession and the insurance carriers.

Resolution No. 9

WHEREAS, Under reorganization of the armed forces, it is proposed to give medical care to some 400,000 civilian employees of the armed forces, and

WHEREAS, Military medicine should be limited to care of military personnel in line with the need of the military to maintain tactical mobility; now, therefore, be it

Resolved, That California Medical Association so direct its forces that the medical care of these civilians be retained in private practitioners' hands and that the armed forces not be permitted to expand their medical services to furnish medical care for these civilians; and, be it further

Resolved, That the California Medical Association carry this resolution to the American Medical Association in San Francisco in June for consideration and action on a national level.

Resolution No. 10

WHEREAS, The California Medical Association's fee schedules are in a state of instability by reason of division of authority between the Industrial Fee Schedule Committee and the C.P.S. Fee Schedule Committee, and special advisory and negotiating committees, and

WHEREAS, The present arrangement also results in needless duplication of effort and expense, and

WHEREAS, Two conflicting schedules exist as a result of such duplication, and

WHEREAS, There is a strong tendency for either of these schedules to be interpreted as a standard of average private fees in California; now, therefore, be it

Resolved, That the present Industrial Accident Fee Schedule Committee and the C.P.S. Fee Schedule Committee be abolished and replaced by a single C.M.A. Fee Schedule Committee, as representative as possible of general practice and the specialties, with sub-committees as necessary, members to be appointed for a three-year term, initially on a staggered basis for continuity of personnel; and, be it further

Resolved, That this committee be instructed to prepare, and maintain by revision as required, a schedule of average fees in California without any minimum or maximum implication; and, be it further

Resolved, That any reduction in the schedule, for instance to C.P.S. and to industrial accident insurance carriers, shall be granted with implication; and, be it further

Resolved, That any reduction in the schedule, for instance to C.P.S. and to industrial accident insurance carriers, shall be granted with emphasis on the fact that such reduction is a concession on the part of our members; and, be it further

Resolved, That this committee shall report to the house of delegates at its annual meeting and any interim meeting.

VICE-SPEAKER CHARNOCK: These resolutions will be submitted to Reference Committee No. 3.

Do we have any more?

DR. FRANK F. SCHADE (Los Angeles): This resolution requests the Governor of the State of California to appoint a physician to membership in the California State Disaster Council.

Resolution No. 11

WHEREAS, Increasing importance is being given to civilian defense, and

WHEREAS, In the event of a major disaster, the care of the sick and injured will be one of the major problems of civilian defense, and

WHEREAS, The California State Disaster Council contains representatives of police and fire officials, representatives of city government and the American Red Cross but no representative of the medical profession; now, therefore, be it

Resolved, That the Governor of the State of California be respectfully petitioned to appoint a physician to the California State Disaster Council, said physician to be a member of the California Medical Association and preferably one who is conversant with the problems of civilian medical defense.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

DR. MILLER: This is a resolution regarding the Benevolence Fund.

Resolution No. 12

WHEREAS, Several years ago a benevolence fund was created by the state association for the worthy purpose of aiding aged and infirm members not able to provide for themselves, and

WHEREAS, One dollar of the state's dues was ordered assigned to this purpose, and

WHEREAS, An increasing number of retired physicians are tending to settle in one of our component counties to the detriment of funds for regular members in that county, and

WHEREAS, The enormous growth of our association may involve a program of tremendous scope, requiring many times one dollar from each and every member, and

WHEREAS, The welfare philosophy of federal aid to states and state aid to counties cannot be projected indefinitely, and

WHEREAS, Most physicians believe that the responsibility of the care of the aged is one best discharged at county level by persons close to the recipient; now, therefore, be it

Resolved, 1. That the benevolence program at state level be discontinued as of January 1, 1951; and, be it further

Resolved, 2. That each and every county society in this state be advised to create suitable funds at county level for the care of disabled or infirm needy physicians; and, be it further

Resolved, 3. That if such physicians wish to move to other counties in their later lives, that the county of their origin may, if funds permit, defray the cost of care in the new county, if the latter has suitable facilities.

VICE-SPEAKER CHARNOCK: This resolution on the benevolent fund will be referred to Reference Committee No. 3.

A MEMBER: Could we have a ruling as to what constitutes a title? Could we have some slight idea what the resolution is about, just merely a short sentence or so.

VICE-SPEAKER CHARNOCK: Yes, just give us a short sentence or so, so we will know what it is all about. Dr. Cook.

DR. ORRIN COOK (Sacramento): This resolution is to the effect that the radio program, "California Caravan," under the sponsorship of the California Medical Association, be discontinued.

Resolution No. 13

Resolved, That the 1950-51 annual budget be revised to the effect that the provision of funds for the radio program "California Caravan" be deleted and that this radio program, under the sponsorship of the California Medical Association, be discontinued.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

Next!

DR. LEON P. FOX (Santa Clara County): This resolution is concerning the establishment of an annual fund of $20,000 to be used by the California Medical Association for public relations.

Resolution No. 14

WHEREAS, There is continually an obvious necessity and imperative need for a strong county medical society local level public relations program in the state, and

WHEREAS, Past experience has repeatedly and forcefully demonstrated that grass roots public relations programs have frequently originated at the level of county medical societies, and

WHEREAS, Such programs have proven to be of such merit as to be adopted on nationwide levels, and

WHEREAS, Such programs are often best introduced as a pilot project for evaluation and trial on a local level, and

WHEREAS, Certain county medical societies which have displayed unusual initiative urgently need financial assistance; be it therefore

Resolved, That the California Medical Association shall establish an annual fund of $20,000 to be used at the county medical society level for those projects in public relations which are approved by the council of the California Medical Association.

VICE-SPEAKER CHARNOCK: It will be referred to Reference Committee No. 2. It has to do with finances.

The next resolution.

DR. H. B. BREITMAN (Los Angeles): This is a proposed amendment to the constitution, article VII, section 1, to be changed to read that delegates or councilors-at-large which are assigned to specific counties by reason of their size shall be elected by delegates from such specified counties.

Proposed Constitutional Amendment

Be It Resolved, That Article VII, Section 1, of the constitution of the California Medical Association be amended to read as follows:

"ARTICLE VII, COUNCIL AND EXECUTIVE COMMITTEE

"Section 1—The Council

"The Council shall consist of the Councilors and ex officio: The President, the President-Elect, and the Speaker of the House of Delegates, each with all the rights of a Councilor.

"Subject to the provisions herein, the Secretary-Treasurer and the Editor shall also be ex officio members of the Council, but without the right to vote.

"The nine district Councilors shall be elected as follows:

"In the interim between the first and second meetings of the House of Delegates at any annual session, the delegates from each Councilor district for which a councilorship is about to become vacant shall meet and elect a Councilor from that district. In the event that a majority of the delegates from any district are unable to agree upon a Councilor, the House of Delegates at its second meeting, shall elect a Councilor from that district. Those councilorships-at-large which are assigned to specified counties by reason of the size of their membership shall in similar manner be elected by the delegates from such specified counties. All nominees for councilorships must be members in good standing.

"Unassigned Councilors-at-Large shall be elected by the House of Delegates. Not more than two Councilors-at-Large shall be elected from any one Councilor district; provided, however, that when any one Councilor district shall consist of a component county society having 1,500 or more members, two of the Councilors-at-Large shall be elected from its membership.

"Any chapters, sections or paragraphs of the Constitution or By-Laws which are in conflict with this amendment are hereby repealed."

VICE-SPEAKER CHARNOCK: That will lie on the table.

DR. BURT DAVIS (Santa Clara): I think the simplest way is to just read the "resolved" portion.

Resolution No. 15

WHEREAS, The public relations program of the California Medical Association was initiated under pressure which required contacting the general public as rapidly as possible, and

WHEREAS, This program has proven effective in publicizing voluntary health insurance, and

WHEREAS, This program, though necessary at the beginning, has been expensive, and

WHEREAS, The general public is now aware of the existence of voluntary health insurance, and

WHEREAS, The radio program "California Caravan" has met the need for which it was designed, but is no longer a necessary nor a justifiable expenditure of the association funds, and

WHEREAS, More efficient techniques for approaching the public at a lesser unit cost per contact are available; now, therefore, be it

Resolved, That the radio program "California Caravan" be discontinued.

The second resolution:

Resolution No. 16

WHEREAS, The 1949 house of delegates encouraged the contact with students of medicine during their training and,

WHEREAS, One of the methods by which this was done was the publication of the pamphlet entitled *Future*, and

WHEREAS, Medical students are more desirous of scientific knowledge than of political knowledge, and better contact may be made by scientific instruction than by political pamphlets; now, therefore, be it

Resolved, That the house of delegates of the California Medical Association suggests to the managerial board of CALIFORNIA MEDICINE that the prepayment of subscriptions to CALIFORNIA MEDICINE for all medical students, interns and residents within California would have many worthwhile benefits in relations with students of medicine; and, be it further

Resolved, That the managerial board be requested to contact agencies whose cooperation might well be enlisted to attain this effect.

The third resolution:

Resolution No. 17

WHEREAS, There has been a growing tendency for organizations with medical administrations to enter upon the field of the practice of medicine, and to make decisions which properly should be made by licensed physicians and surgeons, and

WHEREAS, The business and professions code of the State of California limits the privilege of professional practice of medicine and surgery to natural persons so licensed, and

WHEREAS, This dangerous encroachment upon the practice of medicine and surgery is becoming more evident in the case of hospital administration where the rights and privileges of practicing physicians are being usurped by the administrative bodies, namely, in the invasion of the fields of radiology, pathology, anesthesiology, to name but a few, and

WHEREAS, The rights of hospital staff members are being curtailed by empirical formulation of procedural rules, standing orders, and arbitrary restrictions upon the activities of physicians whose licenses from the State of California are identical and should have an equal weight; now, therefore, be it

Resolved, That a copy of this resolution be sent to each hospital administrator within the state of California.

VICE-SPEAKER CHARNOCK: These will be referred to Reference Committee No. 3.

Dr. J. M. de los Reyes.

DR. J. M. DE LOS REYES (Los Angeles): I have two amendments to the new or the old constitution, gentlemen. The first one will refer to the qualifying of members so that they can be elected to the house of delegates.

The second one is on the oath of office for officers of the association.

. . . The second resolution introduced by Dr. de los Reyes reads as follows . . .

Resolution No. 18

Resolved, That Section 9 is hereby added to Chapter VI of the by-laws of this association, California Medical Association, to read as follows:

"Section 9—Oath of Office

"All officers of this association, upon election or appointment, shall subscribe to an oath or affirma-

tion as follows: "I do not belong and have not belonged to any organization advocating the overthrow or change of the form of government of the U.S.A. by violent or unlawful means nor do I believe in changing the form of government of the U.S.A. by violent or unlawful means."

. . . The first resolution referred to by Dr. de los Reyes appears below as Resolution No. 24. . . .

VICE-SPEAKER CHARNOCK: These will lie on the table.

Do we have any more resolutions?

Dr. Bailey.

DR. WILBUR BAILEY (Los Angeles): This is a resolution asking for a means of recognition of ethical psychologists.

Resolution No. 19

WHEREAS, Properly trained psychologists with high ethical standards who work under the guidance of doctors of medicine render a genuine public service, but

WHEREAS, There are a host of other individuals partly or completely untrained who pose as psychologists, and

WHEREAS, The action of some of these individuals is very much against the public welfare (For example one partly-trained psychologist by way of preventing what he termed a "financial barrier" between him and his patient, borrowed all her money, thus reducing her numerous difficulties to a single package—the problem of getting her money back. Another example is that of a group of women who formerly operated as an escort bureau in one large southern California city, but who have recently paid the city license fee of $12 and registered as psychologists), although the scope of private enterprise has doubtless thus been broadened, it is debatable whether this action is for the general public good, and

WHEREAS, State licensing might seem a ready answer to stopping these "mind meddlers" whose talents range from bunco to blackmail, licensing has two big disadvantages: (1) Nearly anyone who has worked as a so-called psychologist for three to five years would have to be "blanketed in" under a so-called "grandfather" clause; (2) Licensing boards and laws do not always turn out as originally intended; now, therefore, be it

Resolved, That the C.M.A. and the component county societies follow a pattern already successfully established with other affiliated and ancillary groups and set up required standards of education and appropriate codes of ethics for psychologists who work under the direction of the medical profession; and, be it further

Resolved, That a list of such recognized psychologists be made available for the use of the medical profession and the public.

VICE-SPEAKER CHARNOCK: This will be sent to Reference Committee No. 3.

DR. SIDNEY J. THOMAS (Santa Clara): This resolution deals with the attempt of hospital administrators to coerce physicians by using their restrictive beds for making them send patients to the hospitals:

Resolution No. 20

WHEREAS, The C.M.A. continually strives to encourage the highest standards of medical practice, and

WHEREAS, The association believes that free choice of physician is an essential part of the maintenance of such standards, and

WHEREAS, The association is informed that a few hospital administrators are attempting to restrict such choice by requiring that staff members and other physicians desiring to hospitalize patients in such hospitals, direct all private ambulatory outpatients into the departments of those hospitals (for diagnosis, treatment, drugs and other services), and

WHEREAS, The Northern California Retail Druggist Association has already approached officers of the A.M.A. with a request for aid in the termination of such coercive practices; now, therefore, be it

Resolved, That the house of delegates of the C.M.A. deplores such alleged practices on the part of hospitals or hospital administrators; and, be it further

Resolved, That all members of the association be urged to refer their patients to sources based on the highest quality, and who conduct their institutions primarily for the care of those sick and injured in need of bed care; and, be it further

Resolved, That the house direct the executive secretary of the association to transmit copies of this resolution to the grievance committees of the county medical societies in this state, and to the officers of the Association of California Hospitals.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

DR. THOMAS N. FOSTER (Santa Clara County): This is a resolution asking that the funds budgeted for public relations be maintained as they were last year.

Resolution No. 21

WHEREAS, The public relations program of the medical profession has fully justified the expense and effort involved; and

WHEREAS, The hazard of political interference in the practice of medicine still exists despite temporary remission of intensity, and

WHEREAS, It is most urgent that the medical profession not be lulled into complacent false security, and

WHEREAS, An unanticipated shift of public opinion might suddenly occur in the event of a national economic depression; be it therefore

Resolved, That the California Medical Association maintain funds budgeted for their public service program at the same level as that of the previous fiscal year.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

DR. J. B. JOSEPHSON (Santa Clara County): This is a resolution concerning the reorganization of public relations in the California Medical Association.

Resolution No. 22

WHEREAS, Organized medicine in general and California medicine in particular recognize the profound value of public relations, and

WHEREAS, C.M.A. has seen fit to establish an office of executive secretary whose originally intended duty was to initiate and direct the public relations and to streamline the business administration, and

WHEREAS, C.M.A. has seen fit yearly to budget some one hundred thousands of dollars for the sole purpose of improving public relations, almost all of which has been expended on a radio program, thought by many to be immensely costly in proportion to value returned, and

WHEREAS, Such a program of and by itself does not constitute an adequate and well-rounded solution of the problem since it so inadequately expounds the general principles of public relations, and

WHEREAS, The admistrative duties of the executive secretary have been so well organized and delegated to subordinates as to no longer occupy his full time and capacity; now, therefore, be it

Resolved, That the house of delegates of the C.M.A. instructs its council to direct the executive secretary to henceforth give the problem of public relations his major interest, concern and attention, and allow his innative imaginative and creative abilities to conceive, gestate and deliver to California medicine a plan for organized and directive public relations embodying the following: (1) A director of public relations selected from the present secretarial staff or procured from afar whose duties shall be solely public relations, (2) Formulate, execute and direct public relations at the state level, and (3) Advise and assist and cooperate at the county level with help and direction to the county executive secretaries and society officers; and, be it further

Resolved, That the house of delegates of the C.M.A. instruct its council to curtail, reduce or alter its present expenditures on public relations, so as to give necessary financial aid to counties carrying on such a program.

VICE-SPEAKER CHARNOCK: This goes to Reference Committee No. 3.

Do we have any more resolutions?

DR. WALTER WESSELS (Los Angeles): This pertains to a recommendation of the delegates to the American Medical Association for a plea for unification of the inspection of the American College of Surgeons and the A.M.A. and the committees that inspect the hospitals for the training of residents. (Applause.)

Resolution No. 23

At the meeting of the house of delegates in San Diego, Dr. Alson Kilgore has been delegated by a group of hospital staffs in the San Francisco Bay Area to present a resolution with reference to approval for residency programs. The situation at the present time is as follows:

1. The American College of Surgeons has an inspection service and rates certain hospitals for residency programs.

2. The American Medical Association, through the various boards, also has an inspection and rating program for residencies.

3. These programs, as now constituted, do not coordinate, and the American College of Surgeons, for instance, may approve certain hospitals for a three-year residency program in surgery or the surgical specialties. The A.M.A. might come along and with the same hospital not list it for approval or list other hospitals for approval for residencies, for instance, that the American College of Surgeons has not listed.

The resolution which Dr. Kilgore will present will probably cover these three points:

1. That a unified, integrated inspection service should be established with regard to hospital inspection and graduate training programs; in addition, representation should be made concerning the record room system set-up, which has become burdensome, expensive, and unnecessary, as a result of the dual inspection we are now working under.

2. That the rigid 100 per cent specialty practice requirement for diplomates of American boards be relaxed.

3. That these matters be placed before the C.M.A. house of delegates by resolution for transferral to the A.M.A.

[Note: The resolution mentioned was prepared by Reference Committee No. 3 and appears as a part of the report of that committee.]

VICE-SPEAKER CHARNOCK: That will be referred to Reference Committee No. 3.

Next, have we any more? Do we have any more resolutions? We now have 23 resolutions.

Resolution No. 24

(*By* J. M. DE LOS REYES, Los Angeles. See Resolution No. 18).

Resolved, That Subdivision (d) of Section 6 of Chapter III of the by-laws of this association, California Medical Association, is hereby amended by adding to said sub-section (b) at the end thereof a new paragraph reading as follows:

The Committee on Credentials shall require each delegate and alternate and other active member of a component county society who desires to be seated as a member of the House of Delegates, to subscribe under oath and in such form as shall be determined by the Credentials Committee, that he is not and has not been at any time a member of any organization listed, published or held to be subversive by the Department of Justice of the United States of America. In the event of refusal to subscribe to such oath, the Credentials Committee shall not include such person in its written report to the House of Delegates designating the delegates and alternates entitled to membership therein.

. . . The resolution was referred to Reference Committee No. 3. . . .

VICE-SPEAKER CHARNOCK: While we are waiting for the tellers, we have several announcements.

. . . Announcements. . . .

DR. J. LAFE LUDWIG (Los Angeles): Mr. Speaker and members of the house of delegates: I have no resolution to offer at this time. I would like to offer a motion, and that is that a motion of thanks and all that goes with it be extended to the council of the California Medical Association for the fine job they have done for us the past year. Secondly, in case this new constitution does not pass, I would like to make a motion that the reference committee, I believe Committee No. 3, be held as the committeee to carry on their work on this particular program.

VICE-SPEAKER CHARNOCK: We will split that up into two motions. The first motion is that the council be thanked for the work which they have done.

. . . A vote was taken on the motion and it was unanimously carried. . . .

VICE-SPEAKER CHARNOCK: On the suggestion about Reference Committee No. 3, is there a second to that?

. . . The motion was variously seconded, put to a vote and carried. . . .

VICE-SPEAKER CHARNOCK: Dr. Randall, please announce the vote on the new constitution.

DR. RANDALL: "Yes," 56; "no," 158. (Applause.)

DR. LOOS: Mr. Speaker.

VICE-SPEAKER CHARNOCK: The chair will recognize Dr. Loos.

DR. LOOS: I wish to present an amendment to the formerly proposed constitution which has been voted down, to be laid on the table.

VICE-SPEAKER CHARNOCK: It will be laid on the table for one year.

Are there any more resolutions to come before the house? (No response.)

This constitutes the business which has been presented for this evening. A motion is in order to adjourn.

. . . It was moved, seconded and carried that the meeting adjourn. . . .

. . . The meeting adjourned at 12:10 a.m. . . .

HOUSE OF DELEGATES MEETING MAY 2, 1950

The second meeting of the house of delegates 1950 annual session (47th annual session) was held in the Ball Room, Hotel del Coronado, Coronado, California, Tuesday, May 2, 1950. The meeting was called to order at 5:00 p.m. by the speaker of the house, L. A. Alesen, who presided.

SPEAKER ALESEN: Will the house please come to order?

The chair recognizes Dr. Wilcox, the chairman of the Committee on Credentials, who will give us a report on the members registered.

DR. WILCOX: Mr. Chairman, the house of delegates now has a quorum.

SPEAKER ALESEN: We shall proceed now to call the roll. Mr. Secretary.

. . . Roll call. . . .

SPEAKER ALESEN: The next item will be the secretary's announcement of the council's selection of the place for the 1951 session.

SECRETARY GARLAND: The council has selected the city of Los Angeles. (Applause.)

SPEAKER ALESEN: At this time the chair recognizes President R. Stanley Kneeshaw, who will make the presentation of the 50-year pins.

PRESIDENT KNEESHAW: The names of the men who have honorably served the California Medical Association for 50 years are:

Dr. Raymond G. Taylor of Los Angeles.
Dr. A. S. Parker of Merced.
Dr. Charles H. Bulson of Napa.
Dr. Frank Craw of Sacramento.
Dr. John Ballis of Arrowhead Lake.
Dr. H. O. Vonulie of San Francisco.
Dr. William J. Blevin, Sr., of Woodland.

I think there is only one of these gentlemen present. Will the secretary please escort Dr. A. S. Parker to the rostrum? (Applause.)

Dr. Parker, it is my privilege and my honor to present this pin to you for your 50 years of membership in the California Medical Association. I am sure that you have seen many changes in the many years that you have served the people here in California, and I hope that these changes have been for the best, both for the medical profession and for the people of California.

We want to thank you for coming so we could personally show you our esteem and give you this little bit of a token for your services here and in recognition of your having served the people of California these many years.

May you be with us for many, many more years and enjoy the good health that the people are getting from good medical care that is given by the free enterprise system. Thank you, Dr. Parker, for coming. (Applause.)

DR. PARKER: Mr. President and gentlemen: I thank you for the emblem. I am happy to have served the California Medical Association and the people of my community for 50 years. I believe that is all. Thank you.

PRESIDENT KNEESHAW: Thank you, Doctor. (Applause.)

SPEAKER ALESEN: By order of the council, Dr. Sidney Shipman, chairman of that body, will present a supplementary report to the house of delegates.

DR. SHIPMAN: Mr. Speaker, members of the house: The council is not without fault. Nobody realizes that better than the council itself. This morning in executive session the members of the council took the council apart and took themselves apart and arrived at a number of conclusions in which we thought you might be interested and also made some observations which we thought you should know about.

That, therefore, was included in a supplemental report which reads as follows:

1. The council is deeply concerned that maximum efficiency be expected and obtained from our business management. To this end a new firm of auditors has been engaged to audit the books of your association beginning with the next fiscal year. To secure an analysis of office procedures according to modern business methods, and to secure more efficient techniques and proper budgetary controls, the council has directed that the new firm of auditors conduct an over-all survey of the C.M.A. office, or, if they are not prepared to do this, that an independent firm of business analysts be secured for the purpose.

2. The council is concerned with the many standing committees of the association, some of which are largely inactive. Since these committees are provided for in the present constitution and by-laws, it suggests that any new constitution and by-laws be written with this fact in mind. In actual practice in recent years, special committees have been charged with specific duties from time to time, as an efficient method of dealing with certain problems as they arose.

3. The council is convinced that there is not sufficient liaison between members of the council, the house of delegates and the membership of the C.M.A. It recommends that renewed effort be devoted to a consideration of this matter by members of the council as well as members of the house.

4. In recent years it has been the practice to invite the growing number of county society executive secretaries to attend council meetings, not only for the purpose of acquainting them with the work done by the council for use in their component county societies, but also to avail ourselves of their valuable advice. Since great benefit accrues to the council from the presence of those gentlemen, we suggest that it might be proper to defray their expenses from C.M.A. funds, rather than have them borne by the various local societies.

I might say, for my own part, that during this current year the members of the council have been faithful in their attendance and they have worked hard. To those men I wish to extend my very sincere thanks. (Applause.)

SPEAKER ALESEN: The next item on the agenda is the election of officers. The chair will entertain nominations for the office of president-elect of the California Medical Association.

DR. BROWN (Alameda County): Mr. Speaker, members of the house of delegates: It is a very happy privilege for me to nominate for president-elect a friend of many years' standing and a fellow member of the Alameda County Medical Association. We in Alameda County are particularly proud of his achievements. He is an outstanding internist, chief of medical service at Highland Hospital and he has been an active and tireless worker for organized medicine, a past president of the Alameda County Medical Society, delegate to the A.M.A. for six years, and member of the council for the past four years.

For the past year he has been vice-chairman of the council and chairman on the executive committee. As president of the Blue Cross organization, Hospital Service of California, he has gained the knowledge and experience in the field of economics which has made his work to the council and to the state association particularly valuable.

Now as to his personal integrity I can assure you without hesitation that he has never been fingerprinted except voluntarily.

It is, therefore, with great pride and pleasure that I place in nomination for the position of president-elect of the California Medical Association the name of H. Gordon MacLean. (Applause.)

SPEAKER ALESEN: The name of H. Gordon MacLean has been placed in nomination for the office of president-elect. Are there other nominations?

If the chair hears no other nominations, the nominations will be closed. There appearing to be no further nominations, the chair declares the nominations closed.

How do you wish to vote?

. . . There were cries of "By acclamation." . . .

SPEAKER ALESEN: All those in favor of Dr. H. Gordon MacLean as president-elect, signify by saying "aye."

. . . The motion was put to a vote and it was unanimously carried.

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Will the vice-speaker please take the chair?

VICE-SPEAKER CHARNOCK: The next order of business is the nomination of a speaker for the house of delegates.

DR. CRANE: I wish to nominate L. A. Alesen to succeed himself as speaker of the house of delegates. Dr. Alesen needs no further introduction. (Applause.)

VICE-SPEAKER CHARNOCK: The name of Dr. Alesen has been placed in nomination. Are there any other nominations?

The chair, hearing none, declares the nominations closed.

How will you vote?

. . . There were cries of "By acclamation." . . .

VICE-SPEAKER CHARNOCK: All those in favor of Dr. Alesen will signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

VICE-SPEAKER CHARNOCK: Will the secretary please cast the ballot for Dr. Alesen?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

VICE-SPEAKER CHARNOCK: Dr. Alesen is elected.

SPEAKER ALESEN: Thank you. The best I can do to show my appreciation is to talk as fast and quickly as I can and say little.

The next office before you is that of vice-speaker of the house of delegates. Nominations are now in order.

DR. CRAIG (Pasadena): Mr. Speaker, members of the house of delegates: I would like to place in nomination for this office a man whose personality, ability and experience have spoken for themselves. I nominate to succeed himself Dr. Donald Charnock. (Applause.)

SPEAKER ALESEN: The name of Dr. Charnock has been placed in nomination to succeed himself as vice-speaker. Are there any other nominations? Hearing no other nominations, the chair declares the nominations closed.

How will you vote?

. . . There were cries of "By acclamation." . . .

SPEAKER ALESEN: All those in favor of Dr. Donald Charnock as vice-speaker signify by saying "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: Dr. Charnock is declared elected. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Thank you, sir.

The next item of business is the office of district councilors.

First, John D. Ball, Santa Ana.

Mr. Secretary, do you have nominations from the First District?

SECRETARY GARLAND: Mr. Speaker, it is my recollection that a nomination was handed up to the desk yesterday.

I apologize. It is not available here at the moment. Would the person who handed me that nomination please stand up?

Dr. Rees, you handed me a nomination with the name of Dr. John Ball on it?

DR. REES: That is correct.

SECRETARY GARLAND: Mr. Speaker, Dr. John Ball has been nominated.

SPEAKER ALESEN: Dr. John Ball has been nominated. Are there other nominations from the district?

How will you vote?

. . . There were cries of "By acclamation."

SPEAKER ALESEN: There appearing to be no further nominations, the chair declares nominations closed. All those in favor of Dr. John D. Ball signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: Dr. John D. Ball is elected. Mr. Secretary, will you please cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast. (Applause.)

SPEAKER ALESEN: The next item of business is the election of a councilor from the Fourth District. Dr. Axcel E. Anderson's term is expiring.

DR. E. C. HALLEY (Fresno delegation): Mr. Speaker, I wish to memorialize our district councilor. Mr. Speaker, members of the house of delegates: Dr. A. E. Anderson of Fresno, having served continuously as councilor from the Fourth District for the past 15 years, has requested that a younger councilor be elected here tonight to represent his district. Dr. Anderson has served ably and well on the council and has faithfully represented his district in the California Medical Association.

The Fourth District is justifiably proud of his record and accepts his decision with regret.

Mr. Speaker, I move that the house of delegates take due cognizance of Dr. Anderson's splendid service to the California Medical Association and that thanks and appreciation be conveyed in a letter to Dr. Anderson. (Applause.)

A MEMBER: I second the motion.

SPEAKER ALESEN: It is moved and seconded that the sense of Dr. Halley's communication be implemented by the central office. Is there any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Now the nominations, Mr. Secretary, for councilor from the fourth district.

SECRETARY GARLAND: Mr. Speaker, we have the nomination of Dr. Neil Dau of Fresno.

SPEAKER ALESEN: Are there other nominations from this district? If not, the nominations are declared closed.

How will you vote?

. . . There were cries of "By acclamation." . . .

SPEAKER ALESEN: All those in favor of Dr. Neil Dau from Fresno County for councilor of the fourth district, please signify by the usual sign.

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Next is councilor of the seventh district, Donald D. Lum, Alameda, term expiring. Mr. Secretary, the nominations?

SECRETARY GARLAND: Mr. Speaker, we have received 18 valuable autographs, all nominating Dr. Donald Lum to succeed himself.

SPEAKER ALESEN: Are there other nominations for this position from the seventh district? There appearing none, the chair declares the nominations closed.

How will you vote?

. . . There were cries of "By acclamation." . . .

SPEAKER ALESEN: All in favor of selecting Dr. Donald Lum as councilor from the seventh district signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast. (Applause.)

SPEAKER ALESEN: The next item is that there are two councilors-at-large whose terms are expiring. First is Dr. Sidney J. Shipman. Nominations are in order for this position.

DR. GERSON R. BISKIND (San Francisco): Mr. Speaker, the San Francisco delegation has instructed me to place the name of Dr. Sidney Shipman in nomination to succeed himself. (Applause.)

SPEAKER ALESEN: The name of Dr. Sidney Shipman has been placed in nomination to succed himself as councilor-at-large. Are there other nominations? There appearing to be none, the chair declares the nominations closed.

All those in favor of electing Dr. Sidney Shipman to succeed himself signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: Dr. Shipman is declared elected. (Applause.)

Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Next is that of Dr. Wilbur Bailey, term expiring. Nominations are in order.

DR. J. P. SAMPSON (Los Angeles): Mr. Chairman and members of the house of delegates: I should like to place in nomination the name of Wilbur Bailey to succeed himself. (Applause.)

SPEAKER ALESEN: The name of Dr. Wilbur Bailey has been placed in nomination to succeed himself. Are there other nominations from the floor? If not, the nominations are declared closed.

All those in favor of Dr. Wilbur Bailey to succeed himself signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you please cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Next is that of Dr. Francis E. West to fill a vacancy in a term expiring 1951. Nominations are in order.

DR. J. B. PRICE (Orange County): Mr. Speaker, members of the house of delegates: I should like to place in nomination the name of Dr. Francis E. West to fill the unexpired term which he has so capably filled this past year. (Applause.)

SPEAKER ALESEN: The name of Dr. Francis E. West has been placed in nomination to succeed himself. Are there other nominations for this post? If not, all those in favor of electing Dr. Francis West signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Mr. Hunton reminds me we have another councilor-at-large to elect in lieu of the post now held by Dr. H. Gordon MacLean who has been selected as your president-elect. This is the term expiring in 1951.

Nominations are in order for this position.

DR. REYNOLDS: Mr. Speaker and members of the house of delegates: This is one of the functions at this convention that gives me particular pleasure and that is to place in nomination before you the name of a valued and esteemed friend, Dr. Ivan Heron of San Francisco, who is well known to most of you.

Dr. Heron is a graduate of Stanford University. That's bad, but we will forgive that. He has been the past president of the San Francisco County Medical Society; he has been the past president of the California Academy of General Practice. He is at present chairman of the section on general practice at this convention, and he is a fine gentleman. (Applause.)

SPEAKER ALESEN: The name of Dr. Ivan Heron has been placed in nomination to fulfill the unexpired term of Dr. H. Gordon MacLean as councilor-at-large. Are there further nominations? Hearing none, the chair declares the nominations closed.

All those in favor of electing Dr. Heron signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next item on the agenda is that of the selection of delegates to the A.M.A. for terms January 1, 1951, to December 31, 1952. The term of H. Gordon MacLean expires. Nominations are in order.

DR. MACDONALD: Mr. Speaker, house of delegates: It has been my honor to be selected by the Alameda County delegation to place in nomination the name of H. Gordon MacLean to succeed himself. (Applause.)

SPEAKER ALESEN: The name of Dr. H. Gordon MacLean has been placed in nomination to succeed himself as delegate to the A.M.A. Are there any other nominations? Hearing none, the chair declares the nominations closed. All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next gentlemen whose term expires is Dr. E. Vincent Askey. Nominations are now in order.

DR. J. LAFE LUDWIG (Los Angeles): Mr. Speaker, it gives me a great amount of pleasure, and I consider it a great honor to nominate Dr. E. Vincent Askey to succeed himself as delegate to the A.M.A. (Applause.)

SPEAKER ALESEN: The name of Dr. E. Vincent Askey has been placed in nomination to succeed himself as delegate to the A.M.A. Are there other nominations? Hearing none, the chair declares the nominations closed. All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Dr. Askey is elected. Mr. Secretary, will you cast the ballot, please?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Next is Dr. John W. Cline, term expiring.

DR. WARD (San Francisco): Mr. Speaker and members of the house of delegates: I have a little change in routine for you tonight. I have been delegated by the San Francisco delegation to place in nomination for the member of the house of delegates of the American Medical Association for the term expiring of John W. Cline, not John W. Cline but Dwight Wilbur. It gives me great pleasure to present Dr. Wilbur's name in nomination because a few years ago when he was in the service I was honored by being given the nomination and elected to the delegation to take his place. I am sure that the house of delegates of the A.M.A. will be glad to see Dr. Dwight Wilbur back in there pitching again the way he was before the war.

I guess I don't need to explain to you that we expect John Cline will not be available as a delegate to the house of the A.M.A. in 1951, 1952. (Applause.)

SPEAKER ALESEN: The name of Dr. Dwight Wilbur has been placed in nomination to succeed the post now held by Dr. John W. Cline who has been called higher. Are there other nominations for this post? If not, the chair declares the nominations closed.

All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next gentleman whose term expires is Dr. Donald Cass. Nominations are in order.

DR. J. NORMAN O'NEILL (Los Angeles): Mr. Speaker, members of the house of delegates: This is a fine looking group of men and women. I am sure that most of this august body feel the same as I do about the nominee whose name I am going to present. I think that the man in whom this group has the trust and confidence to nominate to that high office of president of the California Medical Association certainly deserves to go back to the American Medical Association, and without further ado it gives me great pleasure to place in nomination the name of Dr. Donald Cass to succeed himself as delegate to the American Medical Association. (Applause.)

SPEAKER ALESEN: The name of Dr. Donald Cass has been placed in nomination to succeed himself as delegate to the American Medical Association. Are there other nominations? If not, the chair declares the nominations closed.

All those in favor of Dr. Cass signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next gentleman whose term expires is Dr. Ralph B. Eusden. Nominations are in order.

DR. JOHN BALL (Orange County): Mr. Speaker, and members of the house of delegates: It is my pleasure and privilege to place in nomination the name of Dr. Ralph Eusden to succeed himself. I have been requested by his own society to do this and although Santa Ana is not in Los Angeles County, we consider ourselves a suburb of Long Beach. It is my pleasure to nominate Dr. Ralph B. Eusden. (Applause.)

DR. DIEPENBROCK (San Francisco): Mr. Chairman, I would like to second the nomination of Dr. Eusden.

SPEAKER ALESEN: Are there other nominations for this post?

DR. REMMEN: May I also second the nomination of Dr. Eusden? It gives me tremendous pleasure to do that, but I think they have it wrong. I think Long Beach is a suburb of Santa Ana.

DR. BULLIS: Mr. Speaker, may I also second that nomination.

DR. PHILIP CUNNANE: Mr. Speaker, I have had a long and great affection for a fine gentleman; knowing him so long and recognizing his capacity, it is a privilege to second that motion.

SPEAKER ALESEN: Dr. Cunnane seconds the motion.

DR. DAU (Fresno County): Mr. Speaker, May I also second the nomination of Dr. Eusden.

A MEMBER: I move the nominations be closed.

SPEAKER ALESEN: Are there other nominations

for this post? Hearing none, the chair declares the nominations closed. All those in favor of the election of Dr. Ralph B. Eusden as delegate to the A.M.A. please signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast. (Applause.)

SPEAKER ALESEN: The next post to be filled is that of an additional delegate to the A.M.A. Our good president, R. Stanley Kneeshaw, now holds that post through council appointment because that vacancy occurred during the interim of the house of delegates.

Nominations are now in order.

DR. BENDER (San Francisco County): Mr. Chairman, members of the house of delegates: I got a great thrill this afternoon when the Santa Clara delegation suggested that I might do a little something for them. So I nominate for the office of delegate to the A.M.A. to succeed himself, our retiring president, Dr. R. Stanley Kneeshaw. (Applause.)

SPEAKER ALESEN: President Kneeshaw is nominated to succeed himself. Are there other nominations? Hearing none, the chair declares the nominations closed. All those in favor of Dr. Kneeshaw signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Thank you, sir.

We now proceed to item (g), alternate to American Medical Association. Dr. Leopold H. Fraser, Richmond, alternate to H. Gordon MacLean.

DR. TRUMAN: Mr. Speaker and members of the house of delegates: I have been requested by the members of the delegation from Alameda County and Contra Costa County to put in nomination the name of Dr. Leopold Fraser to succeed himself. (Applause.)

SPEAKER ALESEN: Dr. Fraser's name has been placed in nomination to succeed himself. Are there other nominations? Hearing none, the chair declares the nominations closed. All those in favor of Dr. Fraser to succeed himself signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Dr. William H. Leake, Los Angeles, alternate to E. Vincent Askey, term expiring. Nominations are in order for this post.

DR. PAUL FOSTER (Los Angeles): Mr. Speaker, members of the house of delegates of the California Medical Association: It is a privilege for me to nominate a very close friend, a man who has the respect of the entire profession both from a county, state and national level. He has been a great help to organized medicine and it is with pleasure that I nominate Dr. H. Clifford Loos as alternate to E. Vincent Askey to the house of delegates of the American Medical Association. (Applause.)

SPEAKER ALESEN: The name of Dr. H. Clifford Loos has been placed in nomination.

DR. SMITH: Mr. Speaker, and members of the house of delegates: District One has been honored to be invited to second the nomination of Dr. H. Clifford Loos as alternate to E. Vincent Askey to the American Medical Association. As you know, District One is composed of Imperial, Orange, Riverside, San Diego, and San Bernardino, and they asked me to convey this second to the house.

SPEAKER ALESEN: Are there additional nominations to this post? Hearing none, the chair declares the nominations closed. All those in favor of electing Dr. Loos signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next post becoming vacant is that of Dr. C. Kelly Canelo, San Jose, alternate to John W. Cline.

DR. FOX (Santa Clara): Mr. Speaker, members of the house of delegates: It gives me a great deal of pleasure to place in nomination the name of Dr. C. Kelly Canelo to succeed himself as alternate to the A.M.A.

SPEAKER ALESEN: The name of Dr. C. Kelly Canelo has been placed in nomination to succeed himself. Are there other nominations? Hearing no other nominations, the chair declares the nominations closed. All those in favor of Dr. Canelo signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: The next position is that of L. Duke Mahannah, Long Beach, alternate to Donald Cass.

A MEMBER: Mr. Chairman, I rise to a point of order. Was Dr. Canelo elected as alternate to Dr. Cline? I don't believe Dr. Cline was a delegate. We had someone else elected as a delegate.

SPEAKER ALESEN: That is right. I beg your pardon. The chair stands corrected. Dr. Dwight Wilbur was elected as that particular delegate.

The next post is that of Dr. L. Duke Mahannah.

DR. JACOBS: Mr. Speaker, members of the house of delegates: I would like to place in nomination for the office of alternate to the A.M.A. the name of Dr. L. Duke Mahannah, who has served for two years as a member of the council of the Los Angeles County Medical Association and who has served three previous terms as alternate delegate to the A.M.A. (Applause.)

SPEAKER ALESEN: The name of Dr. L. Duke Mahannah has been placed in nomination to succeed himself as alternate to Dr. Donald Cass. Are there other nominations? Hearing none, the chair declares the nominations closed. All those in favor of Dr. L. Duke Mahannah signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Now, alternate to the additional delegate to the A.M.A., Dr. Russel V. Lee, incumbent through council appointment, alternate to R. Stanley Kneeshaw. Nominations are in order.

DR. JOSEPHSON (Santa Clara): Mr. Speaker, members of the House of Delegates: It gives Santa Clara County and myself a particular great pleasure to place in nomination the name of Russel V. Lee to continue his office as alternate.

SPEAKER ALESEN: The name of Dr. Russel V. Lee has been placed in nomination to succeed himself in this post. Are there other nominations? There appearing to be none, the chair declares the nominations closed. All those in favor of Dr. Russel V. Lee signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

SECRETARY GARLAND: Mr. Speaker, the ballot is cast.

SPEAKER ALESEN: Thank you, sir.

DR. JAMES B. GRAESER (Alameda): Mr. Speaker, is there an alternate for Dr. Eusden?

A MEMBER: I believe there is an omission in the program, Mr. Speaker. The term of Elizabeth Hohl is expiring and she was alternate.

SPEAKER ALESEN: How about that Mr. Secretary? Is that correct?

SECRETARY GARLAND: Mr. Speaker, there is an omission in the program for which we apologize.

SPEAKER ALESEN: For which the speaker is responsible. I apologize, ladies and gentlemen of the house of delegates. Nominations are in order for the term of Dr. Elizabeth Hohl, alternate.

Thank you, Dr. Graeser, very much.

DR. HOFFMAN: Mr. Speaker, members of the house of delegates: Sunday morning when you got up you saw a new magazine under your doors. This magazine is the result of a great deal of thought and fulfills the desire of the council and this house of delegates. The editor of this magazine is a man who is respected by all of us and a man who must be broad in his field to undertake such a delicate job. Therefore, it gives me pleasure to present to you the name of Dr. J. Lafe Ludwig as alternate to Dr. Ralph Eusden, delegate to the A.M.A. (Applause.)

DR. GRAESER: Mr. Speaker and members of the house of delegates: It gives me a very great pleasure to nominate for this office my former commanding officer on the good ship *Pinkney*, under whom I served for a number of months, Dr. William Costolow. He has had much experience in the affairs of organized medicine. He is now president of the Los Angeles County Medical Association. I place his name before you for this office.

SPEAKER ALESEN: The name of Dr. William Costolow has been placed in nomination. (Applause.)

DR. MURRAY: Mr. Speaker, members of the house: It gives me a great deal of pleasure to second the nomination of Dr. Lafe Ludwig. Dr. Ludwig is now serving on the Legislative Committee. He has been in that capacity for some time and I assure you that he has done a fine piece of work. I shall be very happy to see him made the alternate to Dr. Ralph Eusden. Thank you.

SPEAKER ALESEN: Are there other nominations?

A MEMBER: Mr. Speaker, I, too, would like to second the nomination of Dr. Costolow. I also happened to be on the good ship *Pinkney* and I know Dr. Costolow well and I know he was well served, and would well serve as an alternate.

SPEAKER ALESEN: Are there other nominations for this post?

DR. KIRCHNER (Los Angeles County): Mr. Speaker, I, too, would like to second the nomination of Dr. J. Lafe Ludwig. In case someone feels he has not had experience, I would like to point out the fact he has been a member of the council of the Los Angeles County Medical Association. He has been a delegate here. He is on the executive council of the Medical Veterans of Los Angeles County, and he is on the council of the Public Health League and he is, as Dwight Murray has said, a member of the Legislative Committee. It gives me a great deal of pleasure to second this nomination.

SPEAKER ALESEN: Are there other nominations for this post? Hearing no additional nominations, the chair declares them closed. We will pass the ballot. You are voting for the post of alternate to Dr. Ralph Eusden. The names are Dr. J. Lafe Ludwig and Dr. William Costolow.

We will appoint tellers.

. . . Appointment of tellers. . . .

SPEAKER ALESEN: The last item before we adjourn will be the report of the committee on com-

mittees, Dr. Hartzell Ray. Dr. Hartzell Ray is recognized by the chair.

REPORT OF THE COMMITTEE ON COMMITTEES

DR. HARTZELL RAY: Mr. Chairman, members of the house: I wish to announce the council nominations of new members on the standing committees, and I will mention only the new members that are going on, not the whole committee.

Committee on Associated Societies and Technical Groups, Robert A. Scarborough, San Francisco, 1953.

Committee on Health and Public Instruction, Orrin Cook, Sacramento, 1953.

Committee on History and Obituaries, D. Powell, Stockton, 1953.

Committee on Hospitals, Dispensaries and Clinics, John B. Hamilton, Glendale, 1953.

Committee on Industrial Practice, Raymond Wallerius, Sacramento, 1953.

Committee on Medical Defense, Leslie Magoon, San Jose, 1953.

Committee on Medical Economics, Hallis Carey, Gridley, 1953.

Committee on Medical Education and Medical Institutions, Louis Bullock, Los Angeles, 1953.

Committee on Membership and Organization, Carl L. Mulfinger, Los Angeles, 1953.

Committee on Postgraduate Activities, Ed Rosenow, Pasadena, 1953. And on that same committee, Carroll Andrews to replace another member.

Committee on Publications, George Dawson, Napa, 1953.

Committee on Public Policy and Legislation, Dwight H. Murray, Napa, 1953.

Committee on Scientific Work, Robert L. Dennis, San Jose, 1953.

Physicians' Benevolence Committee, Axcel E. Anderson, chairman; Elizabeth Mason Hohl, and John W. Sherrick.

Mr. Chairman, I move you the adoption of this report.

SPEAKER ALESEN: Do I hear a second?

. . . The motion was seconded, put to a vote, and it was carried. . . .

SPEAKER ALESEN: Dr. Clifford Loos, chairman of the Resolutions Committee No. 3, has an announcement to make to the house at this time. Dr. Loos.

DR. LOOS: Mr. Speaker and members of the house: I want to remind everyone that tonight is the last time in which you can enter any amendments you care to, or not amendments, but any factors that you wish to add to the new constitution as it was put on the table Sunday night. Tonight will be the last chance. That has to stand over for one year before it is voted upon at our next session, and if you have any amendments whatsoever or ideas that you want to put in this new constitution, you must get them in to put on the table this evening. The members of the Reference Committee, Dr. Heron, Dr. Smith, and myself will be around if you care to consult us.

SPEAKER ALESEN: Do you wish to take a recess to return at 7:45 and have the announcement of the election then? What is your wish?

DR. MARTIN: I so move that we adjourn.

. . . The motion was seconded, put to a vote, and it was carried, and the meeting adjourned at 6:30 p.m. to reconvene at 7:45 p.m. the same evening. . . .

RECONVENING OF HOUSE OF DELEGATES

The house of delegates reconvened at 8:00 o'clock p.m. The meeting was called to order by Vice-Speaker Donald Charnock, who presided.

VICE-SPEAKER CHARNOCK: The house of delegates will be in order. The first item of business will be the report of the chairman of the tellers, Dr. Frank Otto.

DR. OTTO: Mr. Speaker, the board of tellers consisting of Dr. Bender, Dr. Donald and myself, announce the election of Dr. Lafe Ludwig. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Lafe Ludwig is declared elected. We will now call on President Kneeshaw to perform a very pleasant duty.

PRESIDENT KNEESHAW: I would like to ask Ben Frees to escort Dr. Leonard Stovall to the rostrum. Thank you, Ben.

Thank you for coming, Dr. Stovall. The California Medical Association wishes to honor Dr. Leonard Stovall of Los Angeles. He is a practitioner in Los Angeles and has been a member of the Los Angeles Association for a good many years. He is outstanding in his district, and he is the first man of his race to be elected to the house of delegates of the California Medical Association. I congratulate you. (Applause.)

DR. STOVALL: Mr. President and members of the house of delegates: This is the greatest honor I have had in my life. It came so unexpectedly. I feel highly grateful to Dr. Ben Frees and Dr. Paul Foster who I am quite sure indorsed me, when my name came up, or maybe they proposed it.

I think I would be very vain to assume this is just a personal honor. I feel that this is more than just a personal honor. It is something that helps to create the good will with the other Negro doctors and to get them interested in the work of the association.

I accept this honor with a sense of guilt, however, because I have done so very little in the way of public boosting of the cause of the County Medical Association or the California Medical Association. But from now on I am going to take an interest. I feel grateful to those doctors who have done so much in campaigning to keep the practice of medicine free and give us all a chance, and I think this gesture of having me in the house of delegates is one of the finest gestures towards making the American democracy a real democracy instead of just some rhetorical phrases. Thank you. (Applause.)

PRESIDENT KNEESHAW: Thank you, Dr. Stovall, and now we have got one more good worker for the cause.

VICE-SPEAKER CHARNOCK: The chair recognizes Dr. Eugene F. Hoffman. Dr. Hoffman.

Well, we will have to recognize him later.

We come now to item seven, reports of reference committees, which will first be the report of Reference Committee No. 1, reports of officers, the council and standing and special committees. Dr. Reynolds.

REPORT OF REFERENCE COMMITTEE No. 1

DR. T. ERIC REYNOLDS (chairman): Mr. Speaker, members of the house of delegates: First of all, I apologize for coming up here to the rostrum instead of to the microphone before me, but taking a cue from Dr. Alesen, I can plead that it is the trouble with the lights instead of perhaps admitting the real reason might be that my knees are shaking and I need to be up here to hide them. (Laughter.)

There are a few words of preamble that I want to say about the report of this reference committee.

The committee consists of Dr. Leslie Magoon, Dr. Ralph Teall and myself as chairman.

We met early yesterday morning with the hope and thought that we could transact our business rapidly enough to permit me to conduct the hearing before the resolutions committee of the California Physicians' Service. However, that was not possible and I had to ask my two colleagues to do all of the work. They deserve most of the credit and I reserve the right to take a third of the blame.

There will be a little of a surprise in this report inasmuch as it is my understanding that it is usually a very perfunctory office to fulfill.

Reference Committee No. 1 meets and with a small amount of hoopla, they pass the thing along and that is it. I have even been told about one occasion when some strong-voiced and heavy-lunged individual prolonged it into many minutes and I fear that ours is going to take a little longer than is usual.

However, your committee has reviewed the reports of the general officers (with the exception of the secretary and executive secretary, whose reports will be reviewed by Reference Committee No. 2), the individual councilors, the president of the trustees of the California Medical Association, the legal department and the editor of CALIFORNIA MEDICINE. We heartily commend all these officers for the energy and intelligence with which they have discharged their responsibilities. Their reports have been printed in the Pre-Convention Bulletin, copies of which have been distributed to all members of the house; you are urged to read them.

Your committee recommends the approval of these reports. Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: The committee recognizes in addition to this the extreme value and earnestness and the amount of work and time that is spent by anyone in organized medicine who takes the trouble to do anything for it and the committee, as an aside and not in its printed report, wishes again to emphasize that any suggestions or criticisms that may occur, are in no manner intended to be of a carping and destructive nature but simply the committee felt that since there was such a committee, its duty was to scrutinize properly the reports as they are printed.

Your committee has reviewed the reports of the following committees: Executive Committee, Committee on Associated Societies and Technical Groups, Committee on Health and Public Instruction, Committee on History and Obituaries, Committee on Hospitals, Dispensaries and Clinics, Committee on Medical Defense, Committee on Medical Education and Medical Institutions, Committee on Membership and Organization, Committee on Postgraduate Activities, Committee on Publications, Committee on Scientific Work, Physicians' Benevolence Committee, the Committee on Public Relations, and the Cancer Commission.

Your committee recommends the approval of these reports. Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: Your committee has reviewed the reports of the Blood Bank Commission, the Committee on Industrial Health, and the Committee on Rural Medical Service.

Your committee recommends the approval of these reports. Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

Your committee has reviewed the written and oral supplemental reports of the Committee on Public Policy and Legislation. We commend Dr. Murray and the members of his committee for the intensity and success of their efforts. Your committee recommends approval of these reports, but would suggest that, in the future, specific recommendations of political candidates by name, not be made in open sessions of this house.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: Your committee has reviewed the report of the editorial board of CALIFORNIA MEDICINE. Your committee recommends the approval of this report, but submits the following: We note that a directive adopted last year by the house of delegates, that representation from the section of general practice be added to the board, has not yet been effected. This committee repeats that recommendation.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: The next section, which was omitted due to last-minute work by other committees, will be omitted and we go on to section seven.

Your committee has reviewed the report of the Advisory Planning Committee. The Advisory Planning Committee consists of the executive secretaries of the component county medical societies, the executive and field secretaries of the C.M.A., the legal counsel of the C.M.A., and the executive director of the Public Health League. It was organized several years ago at the direction of this house to act as an advisory committee to the council.

The report of this committee as submitted is at least technically inaccurate when it states: "The Advisory Planning Committee has continued to meet during 1949, . . ." when, as a matter of fact and to the best of our knowledge, it has met once in the last twenty months. Your reference committee is therefore moved to present the following amended report:

Representing as it does a body of highly trained men, each of whom is well versed in either or both of the fields of economics and public relations, and all of whom are laymen but still fully familiar with, and sympathetic to, the problems of medicine, it would seem that the Advisory Planning Committee should be in a position to render extremely valuable services to the council and the association. But, so far as is determinable, its advice as a committee has on no recent occasion been sought by the council, and its failure to meet by itself cannot but mean that it does not function.

It is felt that for the Advisory Planning Committee to be fully effective and able to serve its highest purpose, the following reforms in its functioning and procedures should be made:

1. The Advisory Planning Committee should formally be organized with appropriate officers, a full record of its proceedings should be kept, and definite channels of communication between the committee and the council should be specified and adhered to.

2. The Advisory Planning Committee should be furnished the proposed agenda of the council meeting, and should consider, and be prepared to recommend concerning any item on that agenda which raises problems related to the fields in which they may be qualified to advise.

3. As a matter of policy and of regular practice, the council should seek the advice of the Advisory Planning Committee whenever the nature of the problem under consideration would make it seem appropriate.

It is believed to be a legitimate and desirable function of the Advisory Planning Committee on its own initiative to devise and develop tentative programs in the various fields of endeavor of the Association for presentation to the council. It is thought that the Advisory Planning Committee should be encouraged to exercise such initiative, and the council should be encouraged in seeking the advice of these experts on economics and public relations who are already conveniently at hand, and who already are on the payrolls of the association or of the component societies.

Your committee recommends the approval of this report as amended.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: Your committee has carefully reviewed the report of the council, and has perceived a tendency for rather hasty action affecting important policy matters. The committee recommends that whenever possible the council give adequate notice and allow all interested affected parties to appear and present their views.

We recommend that, in the future, the council make every effort to try to anticipate and thereby to avoid emergencies which seem to necessitate hasty decision. We also recommend that the council make every effort to keep the membership informed of proposed changes in policy before binding decisions are made on behalf of the C.M.A. as a whole.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

A MEMBER: I would like to rise to a point of order. Would you please inform me on what page this information may be found so the delegates can refer to it? We are listening to a lot of words, and we cannot decipher from the floor exactly what the meaning of this resolution is. Do you have any copies for the rest of us to refer to in your discussion or is this a lot of poppycock we are supposed to swallow as we did some of it?

VICE-SPEAKER CHARNOCK: As the report of the Reference Committee No. 1 has not been mimeographed, this is the only copy.

SAME MEMBER: May I ask why?

VICE-SPEAKER CHARNOCK: I will let the chairman of the committee answer that.

DR. REYNOLDS: The reason why is that there was not sufficient time in which to consult all the interested parties and to prepare a report that could be mimeographed in time.

SAME MEMBER: That is very strange when committee No. 3 has all their reports back and all the copies so we can properly peruse the thing and pass on it in an intelligent manner. I assure you from where I sit and with the surrounding members we have here, we are unable to decipher the intent and meaning of the chair.

DR. REYNOLDS: It is noted that the council has, in many instances, taken to itself some of the functions for which standing committees are provided by our constitution and by-laws. One result is that several standing committees have had little or no function to perform. This is evidenced by reports that such committees did not meet during the year.

Your committee recommends to the House that the by-laws be amended so as to reduce the number and streamline the efficiency of the standing committee.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: It is noted in the reports of the district councilors that there is an increasing use of full-time executive secretaries by component county societies within the various districts. This development is viewed with favor and its extension is strongly urged.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. REYNOLDS: Mr. Speaker, I move the adoption of the report as a whole.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded to receive the report of the reference committee as a whole. Are you ready for the question?

. . . The question was called for, the motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: The chair will now recognize Dr. Eugene Hoffman.

DR. HOFFMAN: Mr. Speaker, members of the house: At the session on Sunday evening you were told that one of our faithful employees, Mr. Ben Read, is convalescing from rather severe surgery.

Mr. Speaker, I move that the secretary be instructed to write a letter commending Mr. Read for his faithful services and wishing him a speedy recovery.

SEVERAL MEMBERS: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that the secretary write a letter to Mr. Ben Read wishing him a speedy recovery. Those who are in favor will signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

DR. HOFFMAN: Thank you, Mr. Speaker.

VICE-SPEAKER CHARNOCK: The next item of business is the report of Reference Committee No. 2 on reports of the secretary-treasurer and the executive secretary, on budget and dues. Dr. Truman will make this report.

REPORT OF REFERENCE COMMITTEE No. 2

DR. STANLEY TRUMAN (chairman): Mr. Speaker, and members of the house of delegates: Your committee has reviewed the report of the secretary and recommends the acceptance of this report, specifically calling to the attention of the council that section of the report recommending that a part-time or full-time physician be employed as secretary. We wish to express the appreciation of the members of the house of delegates and the members of the California Medical Association for Dr. Garland's long and arduous labors in our behalf and express our appreciation for his continued efforts in our behalf.

Mr. Speaker, I move the adoption of this section of our report.

VICE-PRESIDENT CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. TRUMAN: The report of the executive secretary has been reviewed and your committee recommends its acceptance as printed and we wish to express our deep appreciation of the capable services and enthusiastic help of Mr. John Hunton through the year.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Is there a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. TRUMAN: The report of the treasurer has been published in the annual bulletin and this has been made available to the members of the house of delegates. It consists primarily of an audit by the certified public accountants, the auditing firm of Hood and Strong. The committee finds the audit in order and recommends the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER CHARNOCK: Do I hear a second?

. . . The motion was seconded, put to a vote and it was carried. . . .

DR. TRUMAN: Your committee has studied the budget for the 1950-51 fiscal year approved by the council. This budget estimates income for the fiscal year in the amount of $438,200 and expenditures in the amount of $431,350, exclusive of the operations of the official journal, which is budgeted to be self-supporting.

The budget approved by the council includes an item of $150,000 for the association's public relations program for the coming fiscal year. This item has been set to include the continuation of the present radio program, "California Caravan," and also to establish a grass roots public relations program based upon the development of sound fundamental public relations at the level of the county medical society and its individual members.

Your committee feels that the inauguration of the grass roots public relations program is most es-

sential at this time, particularly for its usefulness in providing a foundation of public relations activities on a permanent basis. Accordingly, your committee has approved the inclusion of the item of $150,000 in the budget for the entire public relations program as outlined and approved by the council. However, your committee feels that further consideration should be given to the advisability of continuing the "California Caravan" radio program and your committee recommends that this program be discontinued as of January 1, 1951, unless immediately prior to that time it is the consensus of two-thirds of the members of the council that it is essential to continue the radio program for a longer period in the interests of the over-all public relations of the association. Upon the discontinuation of the present radio program it is the recommendation of your committee that the unexpended balance in the public relations budget item be spent in more effective methods of public relations and publicity activities.

Your committee believes that the budget as recommended by the committee includes sufficient funds to make money available, on the vote of the council, for public relations activities at the county level where such activities are considered to be beneficial for state-wide application. In this belief your committee recommends that no further action be taken on resolution No. 14 introduced by Dr. Leon Fox of Santa Clara County.

The budget as recommended will be a balanced budget on the basis of dues for the calendar year 1951 from $45 to $40 per active member and your committee recommends that the dues for 1951 be $40.

Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be adopted.

DR. DE LOS REYES: Mr. Speaker, may I have the microphone to comment on that part of the resolution?

VICE-SPEAKER CHARNOCK: Yes, indeed.

DR. DE LOS REYES: I see that it has been recommended to you that we delete "California Caravan." So I understand. Is that right?

DR. TRUMAN: As of January 1, 1951.

DR. DE LOS REYES: I don't know how many of you fellows have gone out to speak to service clubs, to women's clubs, to labor unions, but everywhere we go, at least that I go, I find that one of the bright lights regarding public relations in the State of California, is the fact that both the P.-T.A and Federation of Women's Clubs in California have commended this particular part of our public relations. Even the labor unions, as radical as Mr. Bridges and San Pedro are, are willing to agree that "California Caravan" has done a lot of good for California.

I was one of those who were very critical of "California Caravan." As a matter of fact, I was very vocal and very articulate about it, but I have learned that we have been a little bit impetuous and hasty in our criticism.

Since I have gone out I have found that they, and the people of California especially the P.-T.A. and all those people who are particularly as vocal as we are, would like to see "California Caravan" continued.

I understand it costs us $8 a year. Are we willing to cut off our noses to spite our faces for the sake of $8 per member per year when we know according to breakdown there are over 900,000 people in the state of California that are listening to it and believing what is being said in "California Caravan"?

Let's be sensible and let's be practical and let's continue "California Caravan." Again, I repeat, let us not cut off our noses to spite our faces. Thank you. (Applause.)

VICE-SPEAKER CHARNOCK: Is there further debate on this? Dr. Remmen.

DR. REMMEN: Mr. Speaker, is this the opportune time to debate "California Caravan"? There are two resolutions coming up in which "California Caravan" is coming up, and I should think that would be the best time to debate that.

DR. LOOS: Mr. Speaker, we felt this resolution would come up ahead of ours with Reference Committee No. 2, and there would be no action taken on the resolution submitted to No. 3 committee. Therefore, we would prefer to have it debated at this time.

DR. ASKEY: Mr. Chairman, I would like to move an amendment before the debate on this, if I may, sir, for clarification only.

VICE-SPEAKER CHARNOCK: Yes.

DR. ASKEY: I am merely doing this for clarification. It seems that this report is made up of several things and for the basis of clarification only, I think it would be wise if we accepted that part of the report which is not germane to this one subject, that we might not be adopting a lot of things at one time or disabusing and rejecting some things which we might not wish. I therefore move you, sir, that this portion of the report which is given to us dealing with "California Caravan" be made a special order of discussion in order that there may be no misunderstanding as to what we are discussing. I move you that, sir.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that the portion of the report dealing with "California Caravan" be made a special topic of discussion.

. . . The motion was put to a vote and it was carried. . . .

A MEMBER: I rise to a point of order. Is there no discussion?

VICE-SPEAKER CHARNOCK: I am sorry. We will have discussion on it.

A MEMBER: Does that exclude the division of the $150,000? Does that exclude any explanation of the amount of $150,000 and what it is for?

VICE-SPEAKER CHARNOCK: I think the chairman of the reference committee will explain that.

DR. TRUMAN: I shall be very happy to explain that. It will require a little further reading. Shall I read that at this time or do you wish to hear further discussion on "California Caravan?"

VICE-SPEAKER CHARNOCK: I think at this time we should discuss "California Caravan" as the motion just passed has outlined.

DR. TRUMAN: I think that motion was passed out of order because no discussion was had, Mr. Speaker, on that motion. When it was called for, several people wished to discuss it, and no discussion was called for.

VICE-SPEAKER CHARNOCK: All right. We will call for discussion of the motion of Dr. Askey at this time to discuss the proposition of "California Caravan."

DR. TRUMAN: I would like to speak to that if I may, sir.

VICE-SPEAKER CHARNOCK: Go ahead.

DR. TRUMAN: The whole item of "California Caravan" is included as part of the recommended public relations program and I do not see how it can be isolated. If the house of delegates should like to have me explain the full program I shall attempt to do so. If I cannot do so adequately, I think members of the council should be called upon.

VICE-SPEAKER CHARNOCK: Is there any more discussion of this motion at this time? The discussion of the problem of "California Caravan"?

A MEMBER: Mr. Speaker, it cannot be discussed if this is going to close up any discussion of the other items.

VICE-SPEAKER CHARNOCK: No, sir. This is only about "California Caravan."

A MEMBER: As I understood the motion, everything was to be passed except the discussion of "California Caravan."

. . . There were several cries of "No." . . .

VICE-SPEAKER CHARNOCK: The motion was to discuss "California Caravan" separately, aside from every other item in the report.

A MEMBER: I will second the motion as you stated it.

A MEMBER: Mr. Speaker, I move we postpone debate on that motion until after we have heard the full report of the committee.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: That is an amendment to the motion and is in order.

A MEMBER: Mr. Speaker, may I make an amendment to the amendment?

VICE-SPEAKER CHARNOCK: All right. We have an amendment now of the second degree. Is there a question to that? Does anyone want to discuss that?

A MEMBER: What is the second amendment?

VICE-SPEAKER CHARNOCK: The second amendment is that we will hear the rest of the report before we discuss "California Caravan."

. . . Calls for the question. . . .

VICE-SPEAKER CHARNOCK: All those in favor of the amendment to hear all of the report before we discuss "California Caravan" signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: Now, the motion before the house is to discuss "California Caravan" separately.

. . . Calls for the question. . . .

VICE-SPEAKER CHARNOCK: The prevailing question at the present time, and the chair so rules, is that we listen to the report in its entirety, then to discuss "California Caravan." All those in favor of listening to the report, I mean the entire report, will signify by saying, "aye."

. . . The motion was put to a vote and it was carried.

DR. ASKEY: Mr. Chairman, as a point of order, that was passed. The thing before the house is my motion as amended, and if you pass this motion which I made as amended we would then hear the rest of this report, and then take up "California Caravan" and then pass or reject the motion as made by the chair. My motion is before the house as amended, which merely means that we hear his report before you take up "California Caravan" separately if my motion passes.

DR. TRUMAN: Let's do it anyway. (Laughter.)

VICE-SPEAKER CHARNOCK: We will now hear the balance of the report.

DR. TRUMAN: We are all here to try and make progress and arrive at a program that is acceptable and for the best interests of the doctors of California. The council has prepared a public relations program as part of the program for the California Medical Association, and I think that it will take very few moments to give you an idea of what is in the council's mind to tell you that they proposed to call your attention again to the committee's recommended alteration of their program. The report adopted by the council, coming from the Auditing Committee, is as follows:

"The California Medical Association has been engaged since 1945 in a campaign of public education, designed primarily to bring to the attention of the public the knowledge of the availability of voluntary forms of health insurance and the inadvisability of entering into a politically-controlled scheme of compulsory health insurance. The campaign has been directed by Whitaker & Baxter and has succeeded eminently in accomplishing its purpose.

"The present campaign was dictated originally, and has been carried on for five years, by political pressure. It is safe to say that had Governor Warren

not introduced his health insurance bill, the association would not have entered into a public relations campaign of this type.

"The major phase of activity in the current campaign came in 1946 and 1947, when 'voluntary health insurance weeks' were staged in 53 of the 58 counties of the state. This was grass roots campaigning at its best, and it is evident that these county-by-county drives succeeded in arousing a public awareness of the availability of voluntary health insurance. Since the close of the county campaigns, the association's public relations program has consisted almost entirely of the maintenance of a weekly radio program, 'California Caravan.'

"During this five-year period it has become evident that the program being followed was one of an emergency nature and that planning for a long-range campaign to strengthen the underlying relations of the medical profession with the public would require a different approach. The experience gained in Los Angeles, Alameda, Santa Clara, San Francisco, Fresno, Kern, Orange, San Diego, and other counties indicates the need of bringing the importance of sound public relations right down to the county medical society and to its individual members. Just as every physician is regarded as a cancer detection center, so every physician must be regarded as a public relations outlet. The aggregate sum of the public relations of all individual physicians is the public relations of the profession as a whole.

"At the present time the political threat which hung over medicine's head in California in 1945 is still imminent; the 1950 elections are most crucial. Problems of medical service, such as night calls by physicians, overcharges for services rendered, rebates and other difficulties are still with us but are not blatantly and continuously in newspaper headlines. The problem today is one of basic issues, and such measures as are needed to meet specific existing legislative threats.

"On the basis of the above beliefs, the Auditing Committee recommends the establishment of a public relations or public service department within the California Medical Association. The functions of this department would be to develop and put into operation a true grass roots program of public service. Its work would be aimed at a long-range accomplishment of the truest meaning of public relations and would not be spectacular.

"This department should operate directly under the supervision of the council and under the direction of the office of the association. Its personnel should be based upon present personnel, aided by our public relations consultant and where necessary by additional employees to handle field work or office duties which would free persent personnel for field duties.

"The committee has considered carefully the matter of personnel for this program and has decided that present employees of the Association and its affiliated organizations are better qualified to handle this program than would be any newly-employed people. Years of experience are necessary to acquaint any employee with the relationships of the medical profession with the public.

"A review of public relations organizations shows that in nearly every instance the guiding spirit of the organization is a former newspaper man, trained in the use of words and experienced in dealing with people from all strata of life. The association now has three former newspaper men in its employ or that of affiliated organizations. John Hunton, executive secretary, Ed Clancy, field secretary, and Ben Read, executive secretary of the Public Health League of California, all fall into this classification. In addition to their backgrounds in newspaper work, they have long worked with physicians and they are intimate with the problems of the profession.

"The Auditing Committee recommends that these three men, augmented by Mr. Howard Hassard, legal counsel, shall constitute the 'working crew' for the public service program.

"The committee further recommends that this 'working crew' take into continuous consultation a number of other qualified employees of affiliated organizations. Such consultation would be for the twofold purpose of gaining information which these additional people have and for putting into operation the program worked out for statewide consumption.

"The committee calls attention to the fact that in the past ten years the association has grown from a scientific society of some 5,000 members to a vocal active, aggressive organization of more than 10,000 members. Its finances have grown from an annual budget of about $100,000 to one of around $400,000, and its influence in social, economic and political matters has gained immeasurably in stature.

"Along with the growth of the C.M.A. has come a corresponding growth in size and influence of its component county units. There are today full-time executive secretaries in nine of the forty county medical societies, representing 80 per cent of the association's membership. Each of these men is well versed in public service and public relations and each is ready to take on a well conceived and well managed program. In those counties which do not maintain a full-time office and secretary, the services of a state-planned program are particularly needed.

"The committee recommends that each county society executive secretary be made a part of the advisory committee to the 'working crew.' It also recommends that the public relations staffs of associated and affiliated groups and organizations be considered as consultants and assistants in this program. Finally, it recommends that liaison be maintained at all times with the Woman's Auxiliary and with local health officers.

"With the above personnel as both the working and advisory staff, the committee recommends that the program be instituted through personal contacts. The officers and councils of the association should work closely with the 'working crew' in making personal appearances before the county

medical societies. The county-by-county visits of the president and president-elect should be reestablished on a systematic basis, along with a presentation of the public service program by the 'working crew.'

"At the outset, Messrs. Hunton and Clancy would represent the field working staff. On the basis of their experience, field workers could be employed and trained, as the demand for them became evident. If additional employees are needed in the C.M.A. offices to handle routine matters, such employees should be hired.

"The program to be discussed with the county societies and with their members should be the factors already developed or in process of development by the county societies and by the Committee on Medical Economics of the C.M.A. From the information available it is possible to establish standard practices which are aimed at creating favorable public opinion and eliminating questionable practices which react unfavorably against the medical profession in the public mind.

"The Auditing Committee is not prepared at this time to present specific examples of the type of material it envisages in the above recommendations. However, it believes that the county medical societies and their members should be approached with three primary objectives in mind:

"1. Influencing the county medical society to improve the quality of medical care in its area to the point where the public receives nothing short of the best.

"2. Making a study of medical needs and working toward the possibility of making a guarantee to the public of the availability of high-quality medical care for all, regardless of ability to pay.

"3. Making every physician a public service outlet, working for the good of the profession.

"The inauguration of this program would call for:

"1. That 'California Caravan' be continued, but conformed according to the suggestions made by Mr. Whitaker at a recent council meeting (April 29, 1950).

"2. That the use of advertising media, such as radio, newspaper, television, magazines, be utilized as deemed necessary.

"3. The use of news releases on medical topics as well as social, economic, political and scientific.

"The committee recommends that the public relations budget for the 1950-51 fiscal year be established at a maximum of $150,000. This sum is considered ample to launch the proposed enlarged program. The Auditing Committee recommends that the dues of the Association for 1951 be reduced to $40 from $45.

"The Auditing Committee attaches to this report, as a part of it, a proposed 1950-51 budget. This budget includes those items already approved by the council and also the proposed items of $40 for 1951 dues and $150,000 for the 1950-51 public service program."

The committee recommended, and it was accepted, that the budget be established as the reference committee has presented it.

I will be glad to try and answer any questions. (Applause.)

VICE-SPEAKER CHARNOCK: Thank you, Dr. Truman.

The debate now will be on the status of "California Caravan," and Dr. Remmen has already been given the floor.

DR. REMMEN: Mr. Speaker, members of the house and guests: I feel that any consideration of "California Caravan" cannot be made entirely apart from a consideration of the problem of public relations in a somewhat larger sense. Certainly we must have public relations. In these times of problems and stress we must carry our message to the public. I think it is only a question of how we do it, and I think that sometimes we have in our haste—and I blame no one, for in times of war there can be no time to sit down and deliberate on many occasions. But what I have to say is not critical of anyone, nor is it critical of anything that has been done. It is merely an attempt to point out a few of the many facets of the problem of public relations as we face it.

A speaker before a reference committee said yesterday that we laymen know nothing of public relations. He said that we know no more about public relations than our patients know about medicine. I have some patients who know more about pills than I do, and they know it because they have taken so many more pills than I have. I can't give them a pill without a whale of a lot of public relations work and a lot of propaganda in order to get the pill started down, and even then I may have to continue the public relations from day to day, and I am dealing there with a patient who is something of a connoisseur of pills. In other words, he knows something of my profession. He knows it pretty well.

In the field of public relations we deal with matters of everyday experience. We are all salesmen. Every one of you in this room is reasonably successful and he wouldn't be if he hadn't known something of how to approach people, how to influence them and how to sell.

We know what pleases our friends. We know what pleases our families, our children. If you want to put something over at the country club or if you want to get some idea over in one of your groups, you go out and sell it. You don't necessarily haul in a publicity or public relations expert, although I do not question the value of public relations people.

What I am trying to say is we, as the employers, must give very great thought to anything that we undertake or continue along this line. Public relations, or publicity, shall I say, is a very important weapon. It is two-edged. It can come back and ruin you or it can do a very wonderful job for you.

I told the reference committee about the experience of the American Tobacco Company with their campaign against spit. Do you remember the campaign, "Spit is an ugly word. Everybody else's

cigars are made with it, but our cigars are closed in another manner, with water, machinery. Cigars aren't touched by hand," and so on.

What was the big idea? Some high-powered publicity agent caught on that one and went on to carry out their campaign against salivary cigars. What happened? It wasn't very long until every cigar company in the country was screaming, "Cut out that campaign. We are just not selling cigars. Every time anybody sees a cigar they think of spit contamination and the deal is off."

They had to stop that campaign.

Many, many other campaigns on common articles have misfired. Many people won't have a cake of Lifebuoy soap in the house. B. O. is associated with Lifebuoy soap and if there is B. O. in your house, well, maybe your friends will think that you have bought it when they come in.

I only mention that to show some of the kickbacks on public relations. We have had one ourselves. I don't know how many of you have seen it yet, but the opponents, our opponents, the proponents of socialized medicine, have waited until millions of pictures, copies of that grand old painting "The Doctor," had been spread all over the United States as a symbol of the American Medical Association. These gentlemen who desire compulsory health insurance have now taken that picture. They have taken one end of the cottage out. Up in the sky one sees a beautiful vision of a fine, modern hospital with operating rooms, laboratory equipment, the heads of the parents are turned hopefully to look at the vision in the sky of the hospital and the old doctor is still sitting looking down at the child and the caption is, "Do you want the A.M.A.'s kind of medicine or do you want what compulsory health insurance will give you?"

Now, I suppose nothing could be devised that wouldn't kick back. But, nevertheless, is it the part of wisdom to take the medicine of 125 years ago and take a picture which was painted, actually not for glorification of a doctor but to show the pathetic conditions under which the poor lived because the painter was a friend and illustrator for Charles Dickens, and you know his attitude toward poverty.

Well, that is one thing that can happen from public relations, and I think perhaps you should be put on your guard in future programs. Hadn't we better be telling the people about modern medicine? Hadn't we better be telling them what our great researchers have done, about our marvelous clinics, about our brain surgery, how we can take a lung out, about how all that has been developed, and shouldn't we tell them also you couldn't do it for $1 a month or $2 a month? It has got to be done and paid for, and the American public will have to be told that if they want complete coverage including catastrophic coverage that it can't be done for $30 or $40 or $50 a month.

In one of the circulars put out by the A.M.A. at the present time, these statements are made. Understand, I am not objecting to these things. I think much of this work is very fine. I am only trying to point out a few pitfalls for your consideration.

It says there are hundreds of voluntary health insurance plans sponsored by physicians, hospitals, insurance companies, labor unions, industrial concerns, and so on, competing with one another and operating on sound insurance principles. They offer plans to fit the health needs and pocketbooks of every individual and every family.

Now, I ask you, if a family comes to you and says, "Doctor, we don't belong to any employed group, but we would like complete and adequate coverage for all the illnesses that will befall our family," just which one of those plans are you going to recommend to them?

I don't know and I am not in a position at the present time to recommend such a plan because I don't think such plans exist as yet. I think we are going to have to sell the public on what plans we are going to give them.

Further, it says, "The cost is low. Medical and surgery bills, sound protection against major surgical hospital bills cost only ten cents a day for an individual and twenty cents a day for a family, $36 a year or $72 a year for a family."

I am told by some of those who may know something about it that the cost of adequate coverage to a family will probably run $125 to $175 a year. Probably somewhere within those extremes, if you are to cover them properly, give them the care they should have. Now, we are going to have to sell that to the American people, at least to that level of American people who want compulsory health insurance. It isn't an excessive amount for people whose incomes are $3,500, $4,000 or $5,000.

I don't know, I am not an economist, but there is nothing wrong with C.P.S. that couldn't be cured by adequate premiums paid by the people. Let's be frank about this thing. Let's be honest and let's go to the people somehow and tell them we will give them the medical care that they want, but that they will have to pay what it costs, just as they pay for automobiles.

You can't sell them a 1910 Ford, which is comparable to selling them the 1920 doctor. You have got to sell them a modern automobile because that is the only thing that they will buy, and they will sacrifice to pay for it, but first they have got to be convinced of the necessity of it.

I wonder if we have been doing that with C.P.S. or with anything else as yet? It is very difficult to estimate the effects of public relations programs on anything as intangible as public opinion. Certainly you can tell right away whether it is boosting your cigarette sale or your Lifebuoy sale, but public opinion is another matter. That is hard to estimate.

It is said here in a circular put out by the same source, Whitaker & Baxter I think it is, that perhaps the best indication of whether that judgment is sound, lies in the fact that a year ago today you all remember that our major concern outside of stopping the then-threatened legislation was how to get medicine off the defensive.

Today it is off. It is that simple. You start a pub-

licity program and then you don't have to worry. After a year the heat is off.

The heat is not off. We are still on the defensive and we will be on the defensive until such time as we have flooded this country with adequate and complete voluntary health insurance of the type that will give full coverage, and when we have people educated to pay for it as they pay for life insurance or automobiles or refrigerators or everything else.

Now we have made a fine start, but let's not kid ourselves that the heat is off. I have been accused in the past of saying that compulsory health insurance was dead. I never made such a silly statement in my life excepting in a quotation or else regarding the particular item of legislation.

The heat isn't off. We have got a long way to go in a big way, but when I think back ten years, look at what we have accomplished.

In this association or in California we have faced two severe crises. I know Dr. Murray will bear me out that there are lesser crises every year. It isn't something that you can go away and forget.

Back in 1935 when we asked for a compulsory health insurance bill and when Dr. John Harris and his committee of which I was one, were faced with the problem of presenting a compulsory health insurance bill which had been ordered for this house of delegates and which we knew the people didn't want, we had no public relations firm. Nobody ever thought of such a thing. We had no funds. What could you do? Well, all we could do was to let everybody who wanted to get in on that health insurance bill come in and make their suggestions and their demands and fortunately it got so expensive that people wouldn't have it. They weren't used to payroll deductions and that was killed.

Now the recent crisis was an entirely different thing. It grew out of people being cut loose from government payrolls. It didn't grow out of a depression. I certainly don't want to talk all night about this thing. I think we have got to decide and think a lot about how we are going to spend this money. We can't leave that decision entirely to the public relations people. We know the problems and we have got to decide what is to be done.

The public relations person is invaluable in telling you how to get into the papers, how to get on the radio, in writing your script, if you are watching him carefully and in doing much of that type of work, handling the great mailings and all that sort of thing. We have got to decide how it is to be done. What are we going to talk to people about on C.P.S.? Are we going to talk to them about the kind of medical care they are to have; about how much it costs to build a hospital; how much an x-ray machine costs; how much it will cost, and emphasize that it will cost the government at least 100 per cent more to do the same job, or he will get a lot worse quality?

Are we going to in other ways use such motion pictures as the "Snake Pit" which showed the condition of many state mental institutions? Are we going to take pictures out of *Life* and *Look* and spread them around that show the same things?

In other words, are we going to show what government hospitals are, what government medicine is? Are we going to show on the contrary what voluntary medicine is or are we going to above all tell these people they can have the finest of medical care if they are willing to put $10 or $12 into a fund every month; tell them what they will get, but they have got to pay for it and it can't be done for $2 or $3 or $3.50 and be done adequately.

Finally, are we ourselves going to supervise this public relations program? We can't all do it. We have a council and I think it is up to the council either to scan practically every piece of script, every club, everything that goes in, or to have committees or full-time employees of this association who will write and scan such scripts.

I fear I have talked too long, but I thank you. (Applause.)

VICE-SPEAKER CHARNOCK: Thank you, doctor.

We will continue debate on this status of "California Caravan," whether or not it is to be stopped on January 1, 1951, with the reservations by the committee. Is there any more discussion on "California Caravan"?

DR. DONALD: Mr. Speaker, and delegates of the California Medical Association: I have the budget proposed for next year of which $225,000 is put down into two items, department of public relations $150,000, public policy and legislation $75,000. That is $225,000, more than half of the total budget, and it is not broken down and there is no explanation of it.

Regarding the "California Caravan," may I say I am not attacking Dr. Cline or Whitaker & Baxter or any personal member of the council nor have I ever, regardless of Dr. Cline's insinuations. They have done a splendid job. We have had to advertise. We have done it through "California Caravan." It has been pure advertising.

My thesis is that if you will apply $89,000 to the salary of eight executive secretaries of the class that we have in nine counties, that you will do more for public relationship. It is beyond the time now for advertising. You have got to get down and guarantee to everybody in your community, physical care, whether they can pay for it full or part or not at all.

In Alameda County we have done that for two or three years. You can do it. You will get more good public relationship out of satisfaction with your physicians than you will with advertising, and that is the thesis of those of us who want to get ahead with the business that we have got to do and that is protect our patients, first, from lack of physicians' care, second, from overcharging, and that is the basis of Alameda County's work, and I think that such an article as that in *Nation's Business* is worth more than "California Caravan" for a year, and that is why I should like to see "California Caravan" discontinued as of now. Thank you. (Applause.)

DR. LESLIE MAGOON: My county is one that submitted a resolution recommending "California

Caravan" be discontinued. I believe our suggestion was not based on the merits of the program as a publicity medium. Your reference committee chairman pointed out to me very forcibly that I was incompetent to judge that since I admit to never having listened to that program. Our thesis is the same as Dr. Donald's, that for the same money spent in other ways, we can get much more in the way of return. It doesn't seem sensible to us that in a public relations budget of $150,000 over $90,000 or about $90,000 is paid for approximately a three-minute contact, once a week, with about 900,000 people.

I would venture that it is usually the same 900,000. To illustrate what I mean, in our county we have a public relations program that is mediated mostly through newspaper advertising. That program costs us annually about $2,000. At the same time the membership of our county spends about $3,300 for "California Caravan." We think that within the limits of our county as an area, we are getting much more for our $2,000 spent on our program than we are getting from the $3,300 we are spending for "California Caravan." It is a question of emphasis and of getting the most for your money.

We are prepared to accept the proposal of the reference committee which I believe is a reasonable compromise, that "California Caravan" not be stopped abruptly but be stopped as of January 1, unless two-thirds of the association is against it. I recommend the adoption of the reference committee's report. (Applause.)

VICE-SPEAKER CHARNOCK: Is there any more debate?

DR. SHIPMAN: I sense "California Caravan" may not be popular. Your council considered this matter rather exhaustively, and concluded that the report of the Budget Committee should be altered in certain respects.

The council was not unanimous either, any more than this house is, but when it was pointed out that actually the budget for "California Caravan" is included in the overall budget of Mr. Whitaker of Whitaker & Baxter, which is as follows, we changed our minds somewhat. That actual budget has not been presented to the council. It won't be until tomorrow morning, but I don't think I am violating any confidence by giving it to you now.

"California Caravan" radio program, $88,000.

Printing and mimeographing, $3,000.

Travel expense, $2,000.

Telephone and telegraph, miscellaneous expense, $2,000.

Whitaker & Baxter fee, $12,000.

Contingencies, $5,000.

Which brings it an overall figure of $112,000 which is the overall amount to be taken out of the $150,000 which you have heard mentioned.

It was the feeling of the council that inasmuch as the emphasis was to be shifted from C.P.S. to the overall medical program, our defense in Sacramento and in Washington was that "California Caravan" probably provided a worthwhile ace in the hole and we should have it; that all of us could probably afford $9, roughly $9 apiece in order to have an ace in the hole to defend us against adverse legislation.

As far as I am concerned, I would like to make it $90. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Truman, would you continue?

DR. TRUMAN: I might read briefly the part of the committee's report covering "California Caravan" and the item of the dues.

"Your committee recommends that this program be discontinued as of January 1, 1951, unless immediately prior to that time it is the consensus of two-thirds of the members of the council that it is essential to continue the radio program for a longer period in the interest of the overall public relations of the association. Upon the discontinuation of the present radio program, it is the recommendation of your committee that the unexpended balance in the public relations budget item be spent in more effective methods of public relations and publicity activities.

"Your committee believes that the budget as recommended by the committee includes sufficient funds to make money available on the vote of the council for public relations activities at the county level where such activities are considered to be beneficial for state-wide application.

"In their belief your committee recommends that no further action is necessary on Resolution 14 introduced by Dr. Leon Fox of Santa Clara County. The budget as recommended will be a balanced budget on the basis of dues for the calendar year 1951 reduced from $45 to $40 per active member and your committee recommends that the dues for 1951 be $40."

If it is not inappropriate at this time I will, therefore, move the adoption of this section of the committee's report.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any debate? Are you ready for the question?

. . . The question was called for, the motion was put to a vote and it was carried. . . .

DR. TRUMAN: Mr. Speaker, I move the adoption of the committee's report as a whole.

A MEMBER: I second the motion.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept the report of Reference Committee No. 2 as a whole. Is there any debate on this? Are you ready for the question? Those who are in favor of accepting the report of Reference Committee No. 2 as a whole will signify by saying "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. TRUMAN: May I take thirty seconds to thank the members of the committee, Dr. Allen Hinman

and Dr. G. Wendell Olson for spending so much time. This is the first time that Committee No. 2 have ever had a large delegation of members of the house of delegates appear before it and it was quite an experience to have this happen. We appreciate very much the interest in the members of the house of delegates in the budget. Thank you. (Applause.)

VICE-SPEAKER CHARNOCK: Thank you, Dr. Truman.

At this time, the house of delegates will recess. The business session is to be taken over by California Physicians' Service.

. . . The house of delegates recessed to be followed by a meeting of California Physicians' Service. . . .

RECONVENING OF HOUSE OF DELEGATES
May 2, 1950

The meeting of the house of delegates reconvened and the speaker of the house, L. A. Alesen, presided.

SPEAKER ALESEN: The chair recognizes Dr. H. Clifford Loos, chairman of Committee No. 3.

REPORT OF REFERENCE COMMITTEE No. 3

DR. H. CLIFFORD LOOS: Reference Committee No. 3, consisting of Ivan C. Heron of San Francisco, Wesley Smith of San Diego and myself, has held hearings on the 23 resolutions presented to the house and various factors concerning the new constitution presented to you on Sunday evening and wishes to report that there was a large attendance at all hearings and ample opportunity was given to all those interested to participate in the discussions.

Resolution No. 1: Regarding by-law amendments.

The committee recommends that the by-law amendment to Chapter II, Section 2(b) be tabled for one year pending further clarification from the A.M.A., which we understand is under consideration. The second portion of Resolution No. 1, which is a by-law change regarding county secretaries' ability to collect dues, your committee recommends a "do pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER ALESEN: Dr. Loos, we have two items here. For the sake of clarity, we have to take them up one at a time. In the first place, there is no possibility of allowing other than a constitutional amendment to lie on the table. Any other resolution dies with this house as of this present session. Therefore, we will take up the proposed by-law amendment, the first one concerning the A.M.A. and the California Medical Association dues payments.

Is there any question in your minds about the content and the purport of that proposed change in the by-laws, or shall we read it? Do you all have copies?

The vote will be then, upon the adoption or the rejection of this proposed first change in the by-laws. This is an amendment to the by-laws, failure to pay dues. Do you wish further discussion, or are you ready to vote upon that now?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor of the proposed by-law, signify by saying, "aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The chair is in doubt. All those in favor signify by standing.

DR. MAGOON: Mr. Speaker, a point of order. If the chairman of the reference committee is not able to recommend it be tabled, may he be able to make a recommendation that it pass or not pass?

SPEAKER ALESEN: He may, sir. The present voting is still pending. It has not been announced. Therefore, we will allow the chairman to speak.

DR. LOOS: Mr. Speaker, I move that the first section of this resolution be voted "nay."

SPEAKER ALESEN: The recommendation of the committee is that the proposed by-law amendment be rejected. We shall put it in a positive sort of way then. All those in favor of this by-law amendment signify by saying, "aye."

. . . The motion was put to a vote and it was lost. . . .

SPEAKER ALESEN: Now, the second portion of this resolution, which is a by-law change regarding county secretaries' ability to collect dues. Your committee recommends a "do pass."

All those in favor of this by-law amendment signify by saying, "aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: The vote being unanimous, it is declared that this vote is by more than a two-third majority. Therefore, the motion is passed.

DR. LOOS: Resolution No. 2: Regarding the closed panel system. Your committee recommends the adoption of this resolution.

Mr. Speaker, I move the adoption of this resolution.

SPEAKER ALESEN: Is there any discussion? All those in favor of the committee's recommendation signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. LOOS: Regarding a statement of policy of the California Society of Pathologists. Your committee recommends the adoption of this resolution. Mr. Speaker, I so move.

SPEAKER ALESEN: Is there any discussion? Is there a second?

A MEMBER: I second the motion.

SPEAKER ALESEN: All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. LOOS: Resolution No. 4: Regarding future industrial accident fee schedules. Your committee

favors the intent of the resolution but proposes one change in it, the deletion of the mandatory sixty-day requirement of notice to the county societies and substitution of a more flexible requirement to avoid tying the hands of the association for a fixed time interval. The amended resolution is as follows:

Resolved, That any future proposed fee schedule be placed before the component county medical societies and all interested and recognized specialty associations for their study, comment and approval preferably sixty days prior to submission to the Industrial Accident Commission for its final action.

Mr. Speaker, I move the adoption of the resolution as amended.

SPEAKER ALESEN: Is there a second?

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion?

DR. TRUMAN: I would like to suggest that if you mean specialists' associations that phrase includes the general practitioners; I think we should also have the opportunity to consider any amended fee schedules. I have this to suggest, that you make it clear that this includes the general practitioner organization.

SPEAKER ALESEN: You suggest that as an amendment?

DR. TRUMAN: Yes.

A MEMBER: The intent of the resolution was to include all groups.

SPEAKER ALESEN: Well, the chair will rule that is the intent of the resolution and the phraseology will be changed so as to include that. Is there any further discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. LOOS: Resolution No. 5 and No. 6: Regarding C.P.S. fees. These resolutions deal with the same general subject, therefore the committee has combined them into one substitute resolution as follows:

Resolved, That the house of delegates requests the board of trustees of C.P.S. at all times to bear in mind and endeavor to carry out the basic principle that dues charged the public shall be adequate to permit payment of the fee schedule in full rather than at a discount and that in issuing any new types of contracts that it use extreme care to insure as far as humanly possible that the rates charged the public will be adequate to meet the rates in full.

Mr. Speaker, I move the adoption of the foregoing substitute resolution.

SPEAKER ALESEN: Is there any discussion?

DR. HODGES: First of all, I am a general practitioner, and I do not believe in the drawing of any battle lines between specialists and general practitioners in anything and in particular California Physicians' fee schedules. Regarding the adoption of these resolutions, I felt that it was rather timely to introduce a resolution now because of the fact that a new type of coverage, the catastrophic illness coverage, is coming in and this should represent something. This should represent a time at which we could take a new approach toward a realistic fee schedule.

I feel in particular that any such far-reaching plans as a catastrophic illness coverage should be submitted sufficiently early to the professional members of the California Medical Association so that the study of them and consideration could be given in advance.

DR. MAGOON: Mr. Speaker and members of the house: The proposals of this resolution are exactly contrary to the proposals of a resolution that we discussed as administrative members, and that was that the C.P.S. fee schedule, because of its use as a yardstick by the public for all our fees, should be set at a level representing fair private fees, and that we should allow for the fact that our clientele is in a low income group, by discounting those fees certain proportions as experience demonstrates is possible.

On those grounds I would be opposed to the resolution as proposed.

SPEAKER ALESEN: Is there any further discussion?

DR. DAVIS: I would just like to point out from here that this resolution applies to the fees charged the beneficiary members. It does not refer to the rate paid to the doctor.

SPEAKER ALESEN: Is there further discussion? Are you ready for the question?

. . . The question was called for. . . .

SPEAKER ALESEN: All in favor signify by saying, "aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The chair is in doubt. All those in favor will signify by standing.

DR. TRUMAN: May we have some clarification?

SPEAKER ALESEN: Yes, Dr. Truman.

Be seated for a moment, please. Dr. Truman.

DR. TRUMAN: It seems to me that clarification is necessary here. Youtare asking that the rate charged the public be made adequate to meet rates in full, and there are two separate things there. Are you going to ask for payment of rates in full or are you going to ask the rates that the customer pay be raised to meet the rates in full?

SPEAKER ALESEN: Dr. Loos, do you want to answer that, or Dr. Hodges?

DR. LOOS: I think it is quite clear here that the principle is that the fee charged the public shall be adequate to permit payment of the fee schedule in full rather than at a discount, and the intent is that in all contracts that are issued hereafter that the premium rate be sufficiently high to pay the doctor his full charge according to the fee schedule adopted, instead of a percentage of it. That is all new contracts are to be written so the premium should be higher than what it is in the old contracts.

SPEAKER ALESEN: Are you now ready to vote

upon this resolution? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The ayes have it. The resolution is adopted. Proceed, Dr. Loos.

DR. LOOS: Resolution No. 7: Regarding a study of medical and hospital prepayment plans. The committee favors the intent of this resolution; however, probably inadvertently it is limited to medical or hospital service "corporations." A number of prepayment plans are otherwise organized and therefore the committee recommends the deletion of the word "corporation" and the substitution of the word "organization" and as so amended recommends the adoption of the resolution.

Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. LOOS: Resolution No. 8: Regarding indemnity insurance policies. Your committee recommends that, due to the complexity of this resolution, it be referred to the council of the California Medical Association for final action and not be acted upon by the house.

Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion?

DR. MONTGOMERY: I bow to Dr. Parker who wishes to speak first.

SPEAKER ALESEN: Dr. Parker.

DR. PARKER: Mr. Speaker, this resolution which has to do with indemnifying insurance is mainly to be handled by the council and if we had some assurance that the council will make a study on it we could turn it over there. But will your recommendation of your report be turned over to the council and reported back to us?

DR. LOOS: That is right, yes.

SPEAKER ALESEN: Dr. Montgomery, did you wish to discuss this?

DR. MONTGOMERY: I think that covers the point.

SPEAKER ALESEN: Is there further discussion?

. . . The question was called for. . . .

SPEAKER ALESEN: All in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. LOOS: Resolution No. 9: Regarding medical care for the armed services. The committee recommends the adoption of this resolution and so moves, Mr. Speaker.

Mr. Speaker, I move the adoption of this section of the report.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. LOOS: Resolution No. 10: Regarding fee schedule committees. Your committee favors the general purposes embodied in this resolution as presented to the house but because this house cannot order or direct any corporate function of C.P.S. or any committee of C.P.S. it was felt necessary to reword the resolution, which your committee has done. The amended resolution is as follows:

Resolved, That the present industrial accident fee schedule committee of the C.M.A. and the C.P.S. Fee Schedule Committee should be replaced by a single fee schedule committee as representative as possible of general practice and the specialties with subcommittees if necessary, members to be appointed for three-year terms initially on a staggered basis for continuity of personnel; and, be it further

Resolved, That until a single fee schedule committee is in effect all existing committees of the C.M.A. and C.P.S. dealing with fee schedules should integrate their work, pool all facts and data and endeavor to reach uniformity of result; and, be it further

Resolved, That all fee schedule committees ought to prepare and maintain by revision as required, a schedule of average fees in California without any minimum or maximum implication; and, be it further

Resolved, That any reduction in the schedule should be granted with emphasis on the fact that such reduction is a concession on the part of the medical profession; and, be it further

Resolved, That such committees should report to the house of delegates and the C.P.S. administrative members at each annual meeting and at any interim meeting.

Mr. Speaker, I move the adoption of the substitute resolution.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion on this resolution? All in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The resolution is adopted.

DR. LOOS: Resolution No. 11: Regarding civilian disaster committee. We recommend the adoption of this resolution as amended, as follows:

Now therefore be it Resolved, That the Governor of the State of California be respectfully petitioned to appoint the chairman of the C.M.A. Committee on Emergency Medical Service to the California State Disaster Council.

Mr. Speaker, I move the adoption of the amended resolution.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is adopted.

DR. LOOS: Resolution No. 12: Regarding the Benevolence Fund. The constitution requires that one dollar of the annual dues paid by each member be allocated to the physicians' benevolence fund and the by-laws require that the standing Committee on Physicians' Benevolence carry on a program of aid to needy members with the special fund allocated by the constitution. This resolution is in conflict with both the constitution and the by-laws and if acted upon by the house could not accomplish any purpose. For this reason the committee recommends that the resolution do not pass.

I move the adoption of this section of the report.

A MEMBER: I second the motion.

SPEAKER ALESEN: The action now is upon the adoption of the committee's report which recommends the rejection of the resolution. Is there any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The committee's report is adopted. The resolution is rejected. Proceed, Dr. Loos.

DR. LOOS: Resolutions No. 13 and 15: Regarding "California Caravan." Inasmuch as Resolutions Nos. 13 and 15 referring to the "California Caravan" have already been acted upon by the house through the reports of Reference Committee No. 2, your committee feels further action is unnecessary. I recommend that Resolutions No. 13 and 15 be tabled. I so move.

These have already been acted upon by the house, so I think they will be tabled.

A MEMBER: I second the motion.

SPEAKER ALESEN: There is no point in tabling these. These resolutions must die as explained before. No action is necessary. Proceed, Dr. Loos.

DR. LOOS: Resolution No. 14: This resolution was referred to Reference Committee No. 2.

Resolution No. 16: Regarding student liaison. It was the consensus of the committee that anything that can be done to familiarize the students with the practice of medicine was good. However, due to the technical difficulties involved and the lack of available time at present to work out the problems involved, we recommend that this resolution be referred to the council for final action. I move the adoption of this section of the report.

DR. DAVIS: I am happy to see the committee was unanimous in feeling that this was a good idea. However, they seem to be a little bit confused about technical difficulties, and I would like to refer you to page 7 of the resolutions as they were originally introduced, particularly the resolved portions of Resolution No. 16 in which there does not seem to be anything very confusing or any technical difficulties.

The resolved portions said,

"*Resolved*, That the house of delegates of C.M.A. suggests to the managerial board of CALIFORNIA MEDICINE that the prepayment of subscriptions to CALIFORNIA MEDICINE for all medical students, interns and residents within California would have many worthwhile benefits in relation with students of medicine; and, be it further

"*Resolved*, That the managerial board be requested to contact the agencies whose cooperation might well be enlisted to attain this effect."

This is a suggestion. There is nothing compulsory about it. It is an attempt to get some action started, to enable the practicing physicians of the state to become acquainted with the interns and medical students and establish some rapport.

I see no reason in the world why there should be any technical difficulties in getting into effect a suggestion and a request.

SPEAKER ALESEN: The motion is on the committee's recommendation that the resolution be referred to the council. Is there any further discussion?

. . . The question was called for. . . .

SPEAKER ALESEN: The chair is in doubt about the vote. The vote will, therefore, not be determined.

DR. SMITH: Mr. Chairman, the technical difficulties are not those of the committee or of the council but the necessary research that will be necessary regarding postal regulations and the control and the ability to send this magazine. You asked as a suggestion to refer to the council, and this sends it to the council.

DR. DAVIS: Why should this not mean refer to the managerial board with the suggestion that it be done as the original resolution requests?

DR. SMITH: It is.

DR. DAVIS: But you want to refer to the council.

SPEAKER ALESEN: Gentlemen, in the interest of decorum, will you please take the microphone and address the chair, not the speaker?

DR. DAVIS: My point is this: That the house of delegates contact the managerial board of the magazine and suggest that certain things be done, implies that they be done if feasible. We certainly don't expect them to do anything in violation of federal statutes or go to any great length to do something that is totally impracticable. They are requested to put this into effect and contact agencies which might cooperate if necessary. I see no reason why the council should have to go through the entire argument and then request the managerial board to go ahead and start doing something about it. It seems like needless delay.

SPEAKER ALESEN: Is there further discussion? Dr. Loos, do you want to discuss this?

DR. LOOS: Just to this extent. The technical difficulties as Dr. Smith stated, were not those of our committee. There was much discussion on this measure before the committee and many wonderful

ideas were evolved. I believe that there were three to five thousand students and interns that would be involved in this thing which would mean an expense of getting the magazine into the hands of each one of those people.

It was suggested by some that a section of the CALIFORNIA MEDICINE magazine be devoted to interns and students, that a section be incorporated in that. It was also unknown to us about postal laws, whether we could give this magazine away and get it through our second class mail matter. Those things had to be investigated.

Now there is no managerial board of the California Medical Association that I know of. There may be, but I don't know of any. The council is the board of managers, if you wish to call them that. Mr. Hunton is the so-called business manager, if you wish to call him that, but there is no special board to which the council or house of delegates could refer this matter as far as I know, and I think that the matter if it is laid before the council, we will get quicker action than any other way we can do it, and this resolution so advises the council.

. . . The question was called for. . . .

SPEAKER ALESEN: Are you ready for the question? You are voting now on the committee's recommendation to refer the matter to the council. All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. LOOS: Resolution No. 17: Regarding non-medical administration of hospitals. We recommend that this resolution do pass.

SPEAKER ALESEN: Is there a second?

A MEMBER: What is the resolution?

DR. LOOS: Do you want the resolve? It is, "That this house of delegates of the California Medical Association express its disapproval of those hospital administrations and lay organizations which invade this field of activity; and be it further

Resolved, That a copy of this resolution be sent to each hospital administrator within the State of California."

SPEAKER ALESEN: Is there a second?

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there discussion?

DR. BALL: Yes, I would like to discuss that, sir.

SPEAKER ALESEN: Dr. Ball!

DR. BALL: Mr. Speaker, gentlemen: There are in existence today some eight or ten universities of good standing who are training hospital executives. They are non-medical. They are astute. They are carefully selected. They are away from the medical problems. In the majority of cases they are sympathetic.

I think our resolution is out of order in view of the talent available for hospital management. I would like to urge you to reject the resolution.

SPEAKER ALESEN: Is there further discussion on this resolution? Are you ready for the question? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. LOOS: Resolution No. 18: Regarding oath of office. The committee has amended this resolution to read as follows:

Resolved, That Section 9 is hereby added to Chapter VI of the by-laws of this association, California Medical Association, to read as follows:

"Section 9—Oath of Office

"All officers and employees of the association, upon election or appointment, shall subscribe to an oath or affirmation as follows: 'I do not belong and have not belonged to any organization advocating the overthrow or change of the form of government of the U.S.A. by violent or unlawful means nor do I believe in changing the form of government of the U.S.A. by violent or unlawful means.' If, after full hearing, the council shall find that an officer or employee falsely subscribed to the oath or affirmation, it may in its discretion remove the officer or employee from his office or position and fill the vacancy so created."

Mr. Speaker, I move the adoption of this amended resolution.

I move the adoption of this section of the report.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there any discussion?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor of this proposed by-law amendment signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The vote appearing unanimous, it is adopted by more than two-thirds majority. Proceed.

DR. LOOS: Resolution No. 19, regarding recognition of ethical psychologists. Your committee recommends the adoption of this resolution. I so move.

A MEMBER: I second the motion.

SPEAKER ALESEN: Any discussion? All in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is adopted.

DR. LOOS: Resolution No. 20. Regarding resolution on medical practice in hospitals. Your committee recommends the adoption of this resolution. I so move.

SPEAKER ALESEN: Is there a second?

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

DR. LOOS: Resolution No. 21 has already been discussed. The speaker advises me this can be

thrown out. The same refers to Resolution No. 22. It has already been discussed and acted upon.

Resolution No. 23: Regarding correlation of hospital inspection. With permission of the sponsor, a substitute resolution is presented, as follows:

Resolved, That the C.M.A. delegates to the A.M.A. be requested to introduce in the A.M.A. house of delegates the following resolution or, in their judgment, a similar one:

WHEREAS, We have been unofficially informed that the A.M.A., the A.C.S. and the American Board of Surgery have finally agreed upon a unified service of hospital inspection and approval for graduate training in general surgery; and

WHEREAS, This step has been long overdue and it is to be hoped that further steps will follow more promptly for correction of the present intolerable system of bureaucratic dictation of graduate training; now, therefore, be it

Resolved, 1. That the Advisory Council on Medical Specialties, be instructed to authorize no more new specialty boards without specific approval by this house of delegates.

(That refers to the A.M.A. house of delegates, by the way.)

2. That the Council on Medical Education and Hospitals be instructed to offer with adequate publicity in the journal, to extend its unified inspection service to include the other specialties concerned in hospital graduate training programs.

3. The present dictation of graduate training programs by multiple specialty boards responsible to no single coordinating authority is intolerable. The A.M.A. through its councils should never have lost this authority and its officers are hereby directed to regain it (by steps that will be quite obvious) to the end that (a) more reasonable and less rigid training programs be agreed upon, (b) that rigid limitations of practice be abandoned, and (c) that other much needed reforms be adopted.

Mr. Speaker, I move the adoption of this substitute resolution.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is adopted.

DR. LOOS: Resolution No. 24. By-laws change regarding qualification of delegates. The committee suggests amending the resolution as introduced to insure that any delegate rejected by the Credentials Committee shall have the right to appeal to the house. The resolution as amended is as follows:

Resolved, That Subdivision (d) of Section 6 of Chapter III of the by-laws of this association, California Medical Association, is hereby amended by adding to said sub-section (b) at the end thereof a new paragraph reading as follows:

"The Committee on Credentials shall require each delegate and alternate and other active member of a component county society who desires to be seated as a member of the house of delegates, to subscribe under oath and in such form as shall be determined by the Credentials Committee, that he is not and has not been at any time a member of any organization listed, published or held to be subversive by the Department of Justice of the United States of America. In the event of refusal to subscribe to such oath, the Credentials Committee may not include such person in its written report to the house of delegates designating the delegates and alternates entitled to membership therein. Any person refused a seat by action of the Credentials Committee shall have the right to appeal to the house and by majority vote the house may overrule the Credentials Committee and seat such person as a delegate."

Mr. Speaker, I move the adoption of the resolution as amended.

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there discussion?

DR. MAGOON: Mr. Speaker and members of the house: I am opposed to the words, "and has not been at any time," as being too inclusive. I believe it is possible to have belonged to an organization that later was declared to be subversive without at the time knowing that you did so. I think it is sufficient to require that a member specify that he is not now a member of such an organization.

A MEMBER: I second the motion.

DR. WOODWARD: Mr. Speaker, in discussing the amendment proposed by Dr. Magoon, I feel it is extremely important that this resolution be delicate enough to detect all possible subversive individuals and the like, even though we do catch in our net some who at that time are not subversive. Those who are not dangerous to us are not actually subversive and have only been members of such organizations inadvertently can be seated by the house of delegates by a majority vote and having that right of appeal we have also a specific test that will get us the proper delegates.

SPEAKER ALESEN: Is there further discussion on the Magoon amendment?

DR. ALSBERGE: As I sense no feeling in this house that this resolution is not necessary; as I feel that this house realizes that this type of resolution is necessary, I should like to speak to Dr. Magoon's amendment.

In adopting this amendment, gentlemen, you will pull the teeth from the resolution without furnishing any dentures to take their place. It is absolutely impossible with this amendment to fulfill the wish or purpose of the resolution, because all that a man would have to do would be to resign one day and accept his appointment here the next. That is what they are instructed to, and that is what they always do.

We have rather a serious situation in the making. This is for the purpose of forestalling that situation. As far as safeguards are concerned, gentlemen, if a man takes the oath, that is all there is to it. If he does not, if I understand the mechanics of it cor-

rectly, if he refuses to take the oath for a reason and because he belonged to a subversive organization in the past, he reports to the Credentials Committee; the Credentials Committee would weigh his reason therefor and then the matter would be referred to the house of delegates with a recommendation from that committee.

I have no doubt in my mind that on this subject the Credentials Committee will leave the benefit of the doubt in favor of the individual. I am sure that this body is not and will never engage in a witch hunt, but this body must protect itself and this amendment will keep it from doing that.

The resolution if passed as is, will keep this house safe.

DR. DE LOS REYES: Mr. Chairman, I am the father and mother of this resolution. Gentlemen, we have a great danger, and we all admit it, as to what Dr. Magoon brought up here. You have to be sure of this thing and the courts of the United States have ruled that if a man has ever belonged to any organization who later became subversive and that man takes an oath he was not a member of such organization, he is correct because at the time he first joined it was not a subversive organization, and therefore he is not in danger of being called a subversive or his record being smeared and besmirched. I think it is necessary for all of us to be confident.

I agree with Dr. Alsberge. The moment we go ahead and accept an amendment, with the utmost respect for Les, we are going to take out the teeth and it is going to be worthless.

If we are going to be on the front line and fight the battle for so-called Americanism, then we should be the first ones to take the oath and be glad we have taken it.

DR. MAGOON: Mr. Speaker, may I have permission to withdraw my amendment?

SPEAKER ALESEN: Who was the seconder of Dr. Magoon's amendment?

A MEMBER: Nobody.

SPEAKER ALESEN: Is there any objection to Dr. Magoon's request that he withdraw the amendment?

. . . There were cries of "No." . . .

SPEAKER ALESEN: If not, the amendment is withdrawn.

Dr. Carson.

DR. CARSON (San Francisco): I would like to offer an amendment to this resolution as offered. In its present form I do not like it at all for two reasons: Time is very long. Some of these organizations that are held subversive now were not subversive some time back. Some organizations that now are not in bad standing may be odorific by 1953. The other point is that the Attorney General, that is the head of the Department of Justice of the United States Government, is of necessity a political officer. Now, all of us in this room dread the coming of the welfare state which means having everything in the hands of the government. We don't know what sort of an Attorney General we may have at any time, and what attitude he might take.

Therefore, I think that we are laying ourselves wide open by adopting this resolution in its present form, and I would like to offer the following amendment: Namely, that "the Committee on Credentials shall require each delegate and alternate and other active members of the component county societies who desire to be seated as members of the house of delegates, to subscribe under oath an affirmation at this time for them to take the same oath as has been adopted tonight in resolution No. 18, referring to the oath of office for an officer of this organization."

A MEMBER: I second the motion.

SPEAKER ALESEN: Dr. Carson's motion and proposed amendment has been seconded. Is there any discussion?

DR. ALSBERGE: Mr. Speaker, a point of order.

SPEAKER ALESEN: State your point.

DR. ALSBERGE: As delegates, are we not officers of the association?

SPEAKER ALESEN: Will the legal counsel rule on that, please. I believe not.

DR. ALSBERGE: If so, it would be superfluous.

SPEAKER ALESEN: I believe not, doctor. I believe the officers are classified a little differently. Just a moment.

MR. HASSARD: Mr. Speaker, according to the constitution the following are the officers of this association: President, president-elect, secretary-treasurer, speaker, vice-speaker, and editor, and 15 councilors. So the delegates are not officers.

SPEAKER ALESEN: Proceed, Dr. Alsberge.

DR. ALSBERGE: I had hoped not to have to speak at any greater length because the hour was late. However, I find that at least to my way of thinking it is necessary to do so. This amendment would apply only to a proven member of the appeal called the Foley Square or the appeal on the eleven Communist leaders in the United States as to whether or not even they are advocating the overthrow of the government by force and violence. Unfortunately the previous resolution did not contain this.

If this amendment is passed you will be able to carry out your intent against no individual unless you can prove that he is a member of the Communist party because that has been the only one, so designated by the courts, on the left-wing that advocates overthrow of the government by force and violence. The others do the work of the Communists but they are not classified as organizations advocating the overthrow of the Government by force and violence.

In Los Angeles we do have some queer characters. (Laughter.) I think a little background is in order. I am from Los Angeles. I shall try and make my remarks brief, but give you that background.

Last fall in a county election in Los Angeles while I was present with a number of members here, a doctor, a member of our association, stood up and nominated another man to run for office. For-

tunately two of us recognized him with his background. I shall now give you the background of these individuals, and the present resolution would stop none of them.

The doctor who was nominated for the council of the Los Angeles County Medical Association, was sponsor of Leo Gallagher for office of secretary of state on the Democratic ticket in the 1938 California elections; signer of a protest demanding the release of ten Los Angeles Communist leaders jailed for contempt of the Federal Court; sender of eleventh anniversary greetings to the *People's World*; advertiser in the *People's World* when he sent 1949 May Day greetings.

Now the doctor who nominated him was a signer of a protest against the arrest of ten Los Angeles Communist party leaders, signer of a letter to halt extradition of Wiley King, a Communist cause celèbre; member of the reception committee for Max Steinberg, executive director of the notorious Communist front, the American Jewish Labor Council; member of the medical panel of Hollywood Arts, Sciences and Professions Council, a major Stalinist organization; speaker at meetings of the Communist-run Independent Progressive party; signer of Civil Rights Congress petitions. The CRC is the organization currently raising funds for the defense of the eleven convicted national CP leaders.

Backers of this particular doctor include men with this type of record. One doctor in Los Angeles who backed them was sponsor of the Los Angeles Emergency Committee to aid the strikers, a Stalinist-front organization. In 1944 he was in the People's Educational Center in Los Angeles. He was a signer of a brief to the United States Supreme Court in support of John Howard Lawson and Dalton Trumbo, two of the "Hollywood Ten." He protested against the arrest of the eleven Communists in Los Angeles; associated with the California Labor School, Los Angeles branch; sponsored an appearance of Paul Robeson in Los Angeles last September, and a very active member of the Hollywood Independent Citizens Committee of the Arts, Sciences and Professions; active in the American-Soviet Medical Society.

A few of these organizations, gentlemen—all of these organizations do contain innocent individuals; let us remember that. But it is rather hard for me to conceive an innocent individual will join this many front organizations.

Just about two weeks ago he again appeared in the Communist newspaper, the *People's World*, at which time he was quoted as signing a letter to the Attorney General, demanding the immediate dropping of prosecution of the ten Communist leaders in the United States.

I do not intend to give you a detailed discussion of Communism. I could talk for quite some time, several hours, gentlemen, about men that we have, members of our association, who have these ideologies. They made their first attempt and they were only defeated because of the fact that one man nominating him was recognized. Next time they will be smarter. They will send somebody we don't know, and there are plenty of them.

Now the thing I want to drive home is this: That this information was sent out in great detail to every member of the Los Angeles County Medical Association. For reasons that I have heard expressed before the reference committee and elsewhere, because of a fear of infringement upon a person's liberty or for some other reason—and we must not infringe upon those liberties—we must not lose sight of the fact we must protect our way of life and we must think, what will the alternative be?

Then I wish to add that with this information in the hands of every member of the association who was on the mailing list—at least they were mailed—one of the candidates received 20.2 per cent vote and the other in excess of seventeen. I do not wish, gentlemen, these men to be on the floor of the house of delegates using it as a springboard for the publicizing of the briefs of the Stalinists and their organizations.

They cannot be stopped by having to prove that they are members of the Communist party, for two reasons. One, it took a good part of a year and a few hundred thousand dollars or more to convict the eleven leaders of the Communist party, and secondly, the only way you can convict a Communist of being a member of the party, because they no longer carry cards, gentlemen, and have not for some time—the only way that can possibly be done is to find a Communist, an ex-Communist and then have him testify against the man you say is a Communist. Then they immediately call him a stool pigeon and a great portion of the American public, with their fuzzy thinking on the subject, rise and shout, "Slander."

Gentlemen, I move this amendment be defeated.

A MEMBER: I second the motion.

SPEAKER ALESEN: Just a minute. Of course, that motion is out of order. The debate is on Dr. Carson's amendment. Further discussion is out of order.

DR. FAGIN: Gentlemen, I am a neophyte in this organization, and I don't know very much about state medical policy, but I do know this much: That up at Berkeley we had quite a big controversy recently about just such a situation, and the public relations in regard to that were terrible.

Now I don't think that the state medical society in its attempt now to establish good public relations can afford to get involved in a controversy of this sort. The San Francisco *Chronicle* which was mentioned before as coming out in favor of voluntary health insurance, came out very bitterly against this oath, and they came out against it for several reasons, but the main reason was that it didn't get the Communists because they sign it anyway.

It didn't get reactionary average persons but it got liberal individuals whose consciences would not permit them to sign such an oath.

Now we are smart enough to know who are

Communists, and it is enough for us to say, "Is a man a Communist, or is he not a Communist," but to undertake the amount of suspicion that this oath will start, the gathering of physicians, the attempt of one man to malign another in order to get office by saying perhaps he belonged to this organization or perhaps he belonged to that, is wrong. Medicine must build more stately mansions. Medicine must not get involved in this hysteria.

I would like to second the amendment that was just made. (Applause.)

DR. DE LOS REYES: I am sorry, fellows, but I have to speak again.

J. Edgar Hoover said that it is impossible for anyone to say who is a Communist. I would like to know who they are. I attend a lot of the meetings trying to find out who they are. I have never been able to detect one of them.

I am probably the only member of this association that is an American by choice and not by accident of birth, and I have seen totalitarian governments, and I have seen socialism and Communism and I have seen their infiltration, how they got control of different bodies, and this is a thinking body. This is a body that can go ahead through its members and perhaps more people in the United States than any other organization we know of, and we cannot go ahead and allow this amendment to go through. Otherwise the resolution is worthless.

By the way, we in Los Angeles are not the only queer people. In San Francisco they have them also. Several years ago, as one of the executive officers of one of the national fraternities, it was my duty to go there and remove the charter of one of the national medical fraternities. Why? Because fourteen of the men that were there, seven of them seniors, were members of the Communist party, and although we couldn't prove it, their attitude and their records and their actions proved so.

One was the brother of the secretary of the Communist party in San Francisco, a man that had come here as a refugee, or the son of a refugee, and paid for the protection that was given in this country by trying to undermine it.

Please, fellows, let's think carefully about this and let's pass this resolution. (Applause.)

SPEAKER ALESEN: Is there further discussion on Dr. Carson's amendment?

DR. BAILEY: A point of information from Dr. Loos. I don't quite understand why in his committee he didn't amalgamate these resolutions 18 and resolution 24. I don't think there are any among the officers that belong to the Red Guard, but it looks like there is a chance here.

DR. LOOS: Dr. Bailey, that is a technical point, and there is a difference between them, and I am going to ask our legal advisor to explain the difference between those two.

MR. HASSARD: The by-laws contain in one chapter the qualifications of being an officer of the association, and in a separate chapter, some pages farther away, the qualifications of being a delegate. It was necessary to amend sections in both chapters and it would have been more confusing if you had tried to do it in one than in two.

Secondly, while the delegates are not officers and the delegates would only be bound by the resolution that is before you now, if you adopted it, the officers on the other hand are delegates. Therefore, the officers will be bound by this resolution as well as by the prior one that you have already adopted.

. . . There were calls for question. . . .

SPEAKER ALESEN: Are you ready to vote on the amendment?

SECRETARY GARLAND: May I have the floor?

SPEAKER ALESEN: Yes, Dr. Garland.

SECRETARY GARLAND: I happen to be one of those people that Dr. de los Reyes referred to as a somewhat displaced person, a person who has adopted this country and who has had the privilege of serving in the Navy in the last war for three and a half years and proposes to serve again in the next war if he is accepted.

Nevertheless, I agree with the speaker in the back of the hall. The intent of the motion is excellent. The elimination of Communism from our midst will not be achieved by it. It will be thought of as being equally hysterical with those in other parts of the country who are striving to solve our different ideological problems by this method. I don't think it is dignified. I don't think it is worthy of the medical profession.

I move you, Mr. Speaker, an amendment to the amendment to lay this matter on the table.

A MEMBER: I second the motion.

SPEAKER ALESEN: Dr. Garland, what in effect you want to do is kill the entire proposed amendment. It would be impossible merely to move to lay the proposed amendment of the amendment on the table because the amendment is a subsidiary motion. Do you wish to apply the motion to table to the entire matter and not to Dr. Carson's amendment?

SECRETARY GARLAND: Yes, sir.

SPEAKER ALESEN: That is possible, but the chair points out that if you adopt Dr. Garland's motion, you are in effect killing the entire proposed by-law amendment, because it must necessarily die with this present meeting of this session if action is not taken.

This is not debatable. Is there a second?

A MEMBER: I second the motion.

SPEAKER ALESEN: All right. The motion is to lay the entire amendment, not the amendment to the amendment, but the entire proposed by-laws amendment on the table. Are you ready for the question?

. . . The question was called for, the motion was put to a vote and it was lost. . . .

SPEAKER ALESEN: We now recur to a discussion of Dr. Carson's motion.

Dr. Doughty appeals to a decision through the

chair. All those in favor of sustaining the chair signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The chair is sustained.

We recur to a consideration of Dr. Carson's amendment.

SECRETARY GARLAND: Mr. Speaker, a point of order. I think the members of the house were somewhat confused by that last motion.

. . . There were cries of "No." . . .

SPEAKER ALESEN: It is the speaker's belief to the best of his knowledge and ability that the present pending question is that of Dr. Carson's amendment to the proposed amendment of the by-laws. That is to change certain phraseology. Do you wish certain discussion on that point?

DR. CRANE: Mr. Chairman, notwithstanding all that has been said this evening, I don't believe there is an officer or a member in this house of delegates that should refuse at any time to take allegiance to this country in any way, shape or form, and I ask you to defeat this amendment. (Applause.)

DR. ASKEY: Mr. Speaker, I think we are getting pretty well heated up about this thing, and if I weren't heated up about it, I wouldn't get up, because I promised myself I wasn't going to bother you any more.

Ladies and gentlemen, when a question is raised of this type, we are in a peculiar position. I am afraid Harry Garland may be misunderstood. I love Harry Garland. He is just as great a patriot as you or I or anybody else. He thinks it is silly to ask patriots of this type to say this thing and that is why he said it, I am sure, not because he doesn't believe in America. However, the question has been raised. Now listen, gentlemen, if my wife asked me tonight if I still loved her, I am a damned fool if I am not happy to say that I do, and I will be happy to tell her every time she asks me, and if I am afraid to tell her that and refuse to answer, she would be entitled to divorce me and kick me out.

The same thing holds for this. If I am ever ashamed to say I am in favor of the United States of America and never intended to be otherwise, I intend to be kicked out, and therefore, I hope you defeat this resolution. (Applause.)

SPEAKER ALESEN: Are you ready to vote on the Carson amendment?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor of Dr. Carson's amendment signify by saying, "aye."

. . . The motion was put to a vote and it was lost. . . .

SPEAKER ALESEN: The amendment is lost. You now recur to a consideration of the proposed by-law as originally presented. Is there further discussion on that?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Dr. Loos, proceed.

DR. LOOS: Proposed new constitution. Your reference committee introduced at the Sunday evening meeting an entire new constitution which must lie on the table until the 1951 meeting. However, your committee desires to add a subsection (d) to Section 1 of Article III, Part A, reading as follows:

"(d) Ex-officio without the right to vote, the past presidents."

Mr. Speaker, I ask permission to incorporate this addition in the proposed new constitution pending before the house.

SPEAKER ALESEN: Is there any objection to this proposal of Dr. Loos?

DR. J. E. YOUNG (Fresno): Mr. Speaker, a point of information.

SPEAKER ALESEN: State your point.

DR. YOUNG: Is this the place to submit new amendments?

SPEAKER ALESEN: Yes, right now.

DR. YOUNG: May I submit some, Mr. Chairman?

SPEAKER ALESEN: If you have them ready and typed in final form, yes, sir.

Wait a minute. These are amendments for the constitution you are proposing, Dr. Young?

DR. YOUNG: Yes, sir.

SPEAKER ALESEN: And they are in final form?

DR. YOUNG: Yes, sir.

SPEAKER ALESEN: It is in order, yes.

Wait just a minute. We have got a motion before the house.

Is there any discussion on Dr. Loos' proposal? Is there a second to Dr. Loos' final proposal to add this other clause to the constitution to lie on the table? Are you clear what we are talking about?

A MEMBER: I second the motion.

SPEAKER ALESEN: All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The motion wasn't actually needed because any member may introduce a constitutional amendment if he wants to. Let's finish Dr. Loos' report.

DR. LOOS: Mr. Speaker, I move the adoption of this report as a whole as amended.

A MEMBER: I second the motion.

SPEAKER ALESEN: It has been moved and seconded that the report of the reference committee No. 3 be approved as amended. Is there any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Now, Dr. Young, is it going

to take considerable time? Are you going to read them?

DR. YOUNG: No, sir, Mr. Chairman. They are very short.

SPEAKER ALESEN: Proceed. Otherwise we could present them to the secretary.

DR. YOUNG: I can do that, Mr. Chairman. I can give you the title. I propose as an amendment of the proposed constitution of Section 4, Article IV, under the heading of Special Assessments. Mr. Chairman, I propose also a constitutional amendment to the proposed new constitution, of Section 9, Part B of Article III, namely, the composition of the council, and redistribution of the state according to councilor districts.

SPEAKER ALESEN: Will you place those documents in the hands of the secretary? No action of the house is taken at this time.

. . . The documents that were placed in the hands of the secretary are as follows:

Resolved, That Section 4 of Article IV of the constitution of this association, is hereby amended to read as follows:

Section 4, Special assessments, etc.

Funds may be raised by any of the following methods: (a) publications of the association; (b) voluntary contributions, (c) bequests, legacies, devises and gifts, (d) special assessments levied by the house and (e) in any other manner approved by the house. In the event that the house levies any special assessment or other assessment than the annual dues, it may, in the resolution levying the assessment, fix and determine the time within which such assessment may be paid and the class or classes of members upon whom it is levied.

The penalty for failure to pay such assessment shall be levied by the local society.

* * *

Resolved, That Section 9, Part B of Article III of the revised constitution of this association be amended as follows:

"Section 9, Composition.

"The council shall consists of:

"(a) Sixteen district councilors elected from the councilor districts specified in this constitution; and

"(b) Four councilors-at-large elected by the house of delegates, and

"(c) The president, president-elect, and speaker.

"In addition, the secretary-treasurer and editor, ex officio, but without the right to vote."

And that Section 10, Part B of Article III be amended as follows:

"Section 10, Councilor districts.

"(a) The state shall be divided into sixteen councilor districts according to economic and geographic lines. This division is to be effected by the council.

"(b) The state shall be reapportioned at least every five years or oftener if needed by the council.

"(c) The geographical areas of each councilor district and the number of the district shall be as stated in these by-laws."

SPEAKER ALESEN: There is no report by Reference Committee No. 4, is there, Dr. Bullis?

DR. BULLIS: No.

SPEAKER ALESEN: Is there any unfinished business on your desk, Mr. Secretary?

SECRETARY GARLAND: No unfinished business.

SPEAKER ALESEN: Is there any new business?

SECRETARY GARLAND: No new business.

DR. O'NEILL: Mr. Speaker, members of the house of delegates: In the rush and press of business which has taken place here today, I think that we all recognize the splendid job that has been done by Cliff Loos and Dr. Behneman and dozens of others, but some times we are prone to overlook a job well done, and I want to say a word about the Committee on Medical Motion Pictures, the chairman of which was Dr. Arthur E. Smith of Los Angeles.

I am sure if any of you attended any of those sessions you will agree with me that he did an outstanding, bang-up job, and I hope that the Committee on Scientific Work will take official cognizance of his splendid work and remember him when they consider the chairmanship for next year.

If it is in order, Mr. Speaker, I would like to offer a vote of thanks for the outstanding job. I would like to propose a vote of thanks for the outstanding job performed by Dr. Arthur Smith as chairman of the Committee on Medical Motion Pictures. (Applause.)

A MEMBER: I second the motion.

SPEAKER ALESEN: Is there discussion? All those in favor of this motion signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

The chair recognizes Dr. Garland.

SECRETARY GARLAND: Mr. Speaker, the council asked the secretary to prepare some resolutions to extend a vote of thanks of the house to the city of San Diego for its hospitality during this meeting, to all the local committees which worked so hard to make the meeting successful, to the Woman's Auxiliary and the other groups connected with the annual convention.

The council also desired that the house consider a vote of thanks to the various committees of the association which worked on the scientific program and on other phases of the annual meeting.

I submit these to you in this informal form, Mr. Speaker, and will see they are written up correctly if adopted.

SPEAKER ALESEN: The motion is on the adoption of the secretary's proposals.

A MEMBER: I second the motion.

SPEAKER ALESEN: Any discussion? All those in favor signify by saying, "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Any other new business?

DR. HODGES: I wish at this time to take note of the fact that earlier this evening an unfortunate occurrence took place which was in bad taste. I wish to refute any connection between this occurrence and the general practitioners at large. If there is any connection in the minds of the audience I wish to apologize on behalf of the general practitioners. (Applause.)

SPEAKER ALESEN: At this time, ladies and gentlemen, the house of delegates: It is my pleasure to present Dr. Donald Cass, your president for 1951. (Standing applause.)

DR. CASS: I am not only speechless, I am almost breathless. I want to ask you delegates to continue to support the office that I am taking in the same manner that you have supported my predecessors, and I feel you will and I know if you do we will continue to prosper and go ahead in our C.M.A. as we always have in the past. Thanks. (Applause.)

SPEAKER ALESEN: Dr. Ball and Dr. Green, will you please do us the honor of escorting Dr. H. Gordon MacLean to the rostrum?

Ladies and Gentlemen, your president-elect, Dr. H. Gordon MacLean.

DR. MACLEAN: Mr. Speaker, Dr. Cass, members of the house of delegates: Thank you very much for the very high honor. I realize that with this high honor goes quite a responsibility. It is one that will demand a lot of work. Dr. Cass and I have worked together in the house of delegates meeting back at the A.M.A. for approximately six years. We have always gotten along very well together, I assure you, and we will continue to do so.

A long time ago an old friend of mine told me the proper way to make a speech is to make a very short one, have a good beginning, put something in between, and have a good ending.

Now I am at the ending and it is just exactly the same as at the beginning which was thank you very much indeed. (Applause.)

SPEAKER ALESEN: Now the vice-speaker, Dr. Donald Charnock. (Applause.)

Now, ladies and gentlemen of the house of delegates: It is planned to have the officers and council of the association come up here before you and subscribe to the oath that you have indicated that you want them to do. Will the councilors please come up to the rostrum at this time and take this oath showing we mean business?

PRESIDENT KNEESHAW: Face the house of delegates, if you will, raise your right hand and repeat after me:

I, (name) solemnly affirm that I do not belong to and have not belonged to any organization advocating the overthrow or change of the form of Government of the United States of America by violent or unlawful means, nor do I believe in changing the form of Government of the United States of America by violent or unlawful means, so help me God. (Applause.)

SPEAKER ALESEN: The chair recognizes Dr. E. Vincent Askey, who will make a presentation.

DR. ASKEY: Mr. Speaker, members of the house of delegates: I, as your immediate past president, before my good friend that I am going to introduce to you, it becomes the one privilege of the immediate past president to do a very, very wonderful thing from his standpoint and a thing that I appreciate very much.

President Kneeshaw, will you step forward?

Dr. Kneeshaw, we have appreciated the many things you have done for us this year. Your services have been outstanding. They have been of the highest grade and of the greatest integrity.

On behalf of this organization and the officers of the California Medical Association, I wish to present to you this plaque, the President's Plaque, which I hope you will always treasure as I do the one which was presented to me last year, and which is one of my dearest possessions.

May I congratulate you, sir, and give you this plaque with our thanks. (Standing applause.)

PRESIDENT KNEESHAW: Dr. Askey, ladies and gentlemen: I want to thank you. I never was destined to become a public speaker, I am sure, but I will try in my humble way to convey to you my pleasure for having been asked to be your president.

It is indeed an honor, and I hope I deserved that honor and the confidence that you placed in me by electing me two years ago.

I have enjoyed the time I have spent with you. It has been hard work, and I know that I have taken away a lot of time from my home, and I hope my wife will welcome me back home as a stranger would come back to his home.

It gives me great satisfaction to know that you will leave the C.M.A. in the hands of a guy like Don Cass. He is sure a swell fellow and I am sure you will be in good hands that are experienced and know what to do.

He will continue to fight for the things that I have fought for. I wish to thank you ever so much for having elected me as your president. I want to, however, tell you that besides this plaque which I will always think much of, I am sure that I will appreciate the fact that I was the first one to administer the oath to these officers. (Applause.)

That to me, I think, is the best part of it all. I know that this will be appreciated when I get old, and I start to get mellow, but not too mellow, and I hope if there is anything you fellows want me to do, if you will ask me, I will try to do it. Thank you. (Applause.)

SPEAKER ALESEN: A motion is in order that the committee approve the minutes. Ordinarily that is left in the hands of the executive committee of the council. There being no objection, that will be done.

Is there anything else to come before the house?

. . . Announcements. . . .

SPEAKER ALESEN: The meeting stands adjourned.

. . . The convention adjourned at 1:25 a.m. . . .

Questions and Answers about C. P. S.

Question: **What action should I take if a C.P.S. patient does not signify his C.P.S. membership until after I have billed him for services rendered?**

Answer: You should bill C.P.S. as soon as the fact of the patient's membership becomes known. In any case, all bills must be submitted to C.P.S. within six months from the end of the month in which service was rendered. (Note: The C.P.S. Physician Relations Department furnishes small attractive desk plaques for doctors' offices on which is printed the reminder that patients should present C.P.S. membership cards on the first visit.)

Question: **Does C.P.S. pay additional fees for post-operative care?**

Answer: (a) If there is a "T" after the fee payment in the Fee Schedule, there is no additional fee for after visits, unless exceptional complications develop.

(b) If there is an asterisk (*) after the fee payment in the Fee Schedule the fee is only for the primary procedure, and all after visits are paid for additionally by C.P.S.

(c) If there is no mark on the Fee Schedule, the fee includes two weeks' after-care and C.P.S. pays for necessary after visits beyond that time.

Question: **If a C.P.S. patient who has Two-Visit Deductible medical coverage has paid for the first two visits to one doctor and is referred by that doctor to a second doctor for treatment of the same ailment, is the patient again responsible for the first two visits?**

Answer: No. Holders of Two-Visit Deductible medical coverage are responsible for only the first two visits for each ailment, even though they may be referred to a second doctor. (Note: All referrals should be indicated on the billing form.) However, if the patient changes of his own accord, he is again responsible for the first two visits.

Question: **How do I handle the veteran who comes to my office and *demands immediate treatment?***

Answer: By telling him that the V.A. will not pay for visits made before authorization is issued and that, therefore, you must bill him as a private patient until authorization is received.

In actual emergencies, authorization may be secured by telephone to either the San Francisco or Los Angeles C.P.S.-Veterans offices after service connection has been established.

Question: **After a veteran's case has been established as service-connected, and I have authority to treat him, why must I ask for a new authority every month?**

Answer: Because to pay for every authorization issued, actual money must be encumbered in advance in the budget for that period, and funds must be ear-marked in advance for payment of each subsequent authorization as treatment progresses.

Question: **May I bill C.P.S. patients for any difference between the C.P.S. fee and my regular charge?**

Answer: The answer depends on whether the patient's income is over or under the income ceiling. Under terms of physician-members' membership in C.P.S., if income is under the ceiling, they *may not* charge the difference between the C.P.S. fee and their usual fee. If income is over the ceiling, doctors are entitled to charge the difference between fees. The income ceiling also applies to x-ray and laboratory services. (Note: The income ceiling for all C.P.S. members, except Grange members, is $3,600 annual gross family income from all sources, for the preceding calendar year. For Grange members it is $3,600 *net* family income as computed for Federal income tax for 1949.)

Question: **Are payments for routine physical examinations or check-ups provided under any C.P.S. contract?**

Answer: No, because C.P.S. covers only active illnesses and injuries.

Question: **This being vacation time, some of my patients ask me if their C.P.S. benefits extend outside California. What is the rule on this?**

Answer: C.P.S. benefits are available anywhere in the world. For members who are traveling or temporarily residing outside California, C.P.S. will pay up to the amount paid to California physician-members and hospitals for like services, provided the services have been rendered by a licensed physician, surgeon or hospital. Patients should pay the bill and then claim reimbursement from C.P.S., submitting the receipted bill with the claim.

Question: **What is the interpretation of the "three months' chronic condition clause" as regards the period during which a C.P.S. patient is eligible for treatment of a chronic condition?**

Answer: The interpretation of this clause is that the patient is entitled to three *consecutive* months' treatment for a chronic condition. In other words, contract benefits for a chronic ailment expire three months after the date that the patient first utilizes his C.P.S. coverage for that condition, regardless of the amount of treatment received during the three months. The clause does not mean three months' care at broken intervals.

Question: **What surgical treatment, if any, can be given a veteran under the C.P.S.-V.A. Home Town Medical Care Plan?**

Answer: Only minor operations which have been authorized by V.A. and can be performed safely in the doctor's office, or on a "come and go" basis in a hospital. "Come and go" means use of minor operating room facilities in the outpatient department and less than an overnight stay with no meals served. The condition must be service-connected.

NEWS and NOTES

NATIONAL • STATE • COUNTY

LOS ANGELES

Appointment of **Dr. Pauline O. Roberts** as assistant district health officer of the southeast and southwest districts of Los Angeles was announced last month by Dr. George M. Uhl, Los Angeles city health officer.

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The **Second Postgraduate Assembly,** sponsored by the staff of Saint John's Hospital, Santa Monica, will be held September 11, 12, 13, 1950. There will be panel discussions on diseases of the kidneys, parenteral fluid balance, focal infections, ACTH and cortisone, and cirrhosis of the liver, and seminars will be held on pediatrics and obstetrics.

RIVERSIDE

Dr. Everett Stone recently was appointed Riverside County health officer to succeed Dr. Robert Westphal who resigned to become health officer of Sonoma County. Dr. Stone had been Dr. Westphal's assistant.

SAN FRANCISCO

A **World Health Organization** fellowship has been awarded to Dr. E. Richard Weinerman, visiting associate professor of medical economics and head of the division of medical care administration at the University of California School of Public Health. Dr. Weinerman will study teaching and research programs in the preventive and social aspects of medicine being carried out by various European universities.

* * *

The Borden Foundation Undergraduate Research Award, a cash prize of $500, given to the member of the graduating class of the University of California School of Medicine for the best original research, this year was presented to Eugene Eisenberg for his work on the steroid hormones. **A special award** of $250, given anonymously, was presented to John Langton in recognition of his research on pain patterns.

YUBA-SUTTER-COLUSA

Dr. Edith Young, formerly Sonoma County health officer, has been appointed health officer of the bi-county Sutter-Yuba Health Department. She succeeds Dr. Carl A. Scherer who resigned because of ill health.

GENERAL

The Los Angeles Heart Association and the heart division of the San Francisco Tuberculosis Association will hold **postgraduate symposiums on heart disease** in October. The meeting in Los Angeles is scheduled for October 18 and 19 in the Wilshire-Ebell Theater, and the San Francisco meeting for October 25-28 at the St. Francis Hotel. Guest speakers at both meetings will be Dr. George Pickering, professor of medicine, University of London, and Dr. Carl J. Wiggers, professor of physiology and director of the department of physiology, Western Reserve University, Cleveland.

The American Congress of Physical Medicine will hold its 28th annual scientific and clinical session August 28, 29, 31 and September 1, 1950, inclusive, at the Hotel Statler, Boston. All sessions will be open to members of the medical profession in good standing with the American Medical Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

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Effective since June 1, the **new fee schedule for the CPS-VA** Home Town Care Program brings a general increase in payments to physician-members for services rendered to veterans with service-connected disabilities. The higher fees are the result of negotiations that had been under way between C.P.S. and the Veterans Administration since the standard C.P.S. fee schedule for the commercial program was introduced in September, 1949. With but few exceptions, the new veterans' fee schedule has now been brought into conformity with the commercial schedule.

Of particular interest to physician-members is that payments for office visits have been increased from $2.50 to $3.00, while payments for follow-up home visits have been raised from $3.75 to $5.00. These higher fees are of greater significance when it is considered that by far the largest percentage of all C.P.S. payments are for home and office visits. Also of importance is the fact that payments under the veterans' fee schedule, as in the past, are made at the full schedule rate.

* * *

Award of four grants to California institutions to aid in **research on diseases of the heart and arteries** was announced last month by the Life Insurance Medical Research Fund. In addition, a postgraduate research fellowship was awarded to a California physician.

The awards to institutions:

Scripps Metabolic Clinic, La Jolla, for research by Dr. Eaton M. MacKay on the metabolism of pressor amines in relation to hypertension, $2,625.

Stanford University School of Medicine, San Francisco, for research by Dr. Emile Holman on experimental valvular disease, cardiac anastomoses, and hemodynamics, $5,880.

University of Southern California School of Medicine, Los Angeles, for research by Dr. Clinton H. Thienes on cellular mechanisms in the action of drugs on the cardiovascular system, $8,925.

University of California School of Medicine, Berkeley, for research by Dr. I. L. Chaikoff on the metabolic characteristics of arterial tissue and the pathogenesis of arteriosclerosis, $18,795.

The fellowship was awarded to Dr. Gordon M. Tomkins, of Los Angeles, for research under the supervision of Dr. I. L. Chaikoff at the University of California School of Medicine, Berkeley.

* * *

The American Society for the Study of Sterility offers an annual award of $1,000, known as the Ortho Award, for an outstanding contribution to the subject of infertility and sterility. Competition is open to those in clinical practice as well as individuals whose work is restricted to research in the basic sciences. Essays submitted for the 1951 contest must be received not later than March 1, 1951. The prize essay

POSTGRADUATE EDUCATION NOTICES

For more complete information as to fees and time of sessions address the institutions as listed.

JULY 1950

University of California at Los Angeles School of Medicine

Diagnosis and Therapy of Cancer—July 17 to 22, 1950.

Address: 813 South Hill Street, Los Angeles.

AUGUST 1950

University of California at San Francisco, Langley Porter Clinic

Psychiatry and Neurology—August 28 to November 17, 1950.

Address: Stacey R. Mettier, M.D., Professor of Medicine, Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22, California.

SEPTEMBER 1950

University of Southern California, School of Medicine

Clinical Review of Internal Medicine—12 weeks full-time from September 11 to December 1, 1950.

Cardiology and Vascular Disease—12 months, full-time from September 11, 1950 to September, 1951.

Hematology—12 weekly, 2-hour evening lectures. Clinical application of newer diagnostic methods in cardiology. Given at Los Angeles County Hospital.

Recent Advances in Surgery, Obstetrics and Gynecology—Given in San Diego.

Electrocardiography—Given at Centinela Hospital, Inglewood.

University of California at Los Angeles

Symposia on Therapy in Metabolic, Endocrine and Gastrointestinal Diseases—September 20 to December 13, 1950. Wednesday evenings, 8 to 10 p.m.

Surgical Anatomy—September to December, 1950.

Stanford University, School of Medicine

September 11 to 15.

Morning Courses: Monday, Tuesday, Wednesday, Thursday and Friday, 8:30 a.m. to 12 noon.

Course 1—General Surgery
Course 2—Acute Surgical Emergencies
Course 3—Surgical Anatomy
Course 4—Internal Medicine
Course 5—Electrocardiography
Course 6—Diseases of the Chest
Course 7—Pediatrics

Afternoon Courses: 1:30 to 5 p.m.

Course 8—Surgical Anatomy
Course 9—Proctology
Course 10—Fundamentals of Roentgen Diagnosis
Course 11—Fractures
Course 12—Internal Medicine
Course 13—Obstetrics and Gynecology

Address: Stanford School of Medicine, 2398 Sacramento Street, San Francisco 15, California.

OCTOBER 1950

University of California at Los Angeles

Recent Advances in Obstetrics and Gynecology—One week.

NOVEMBER - DECEMBER 1950

University of California at Los Angeles

Ophthalmology.

DECEMBER 1950

University of California at Los Angeles

Internal Medicine—9 months full-time, December 4, 1950 to September 1951.

JANUARY 1951

University of California at Los Angeles

Advanced Hematology—Eight lectures.

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TWO-DAY MEDICAL INSTITUTES, sponsored by the COMMITTEE ON POSTGRADUATE ACTIVITIES and by the local county society in each locality (exact dates to be announced later).

Santa Barbara in October 1950.

Fresno in November 1950.

Riverside in January 1951.

Santa Rosa in February 1951.

Sacramento in March 1951.

will appear on the program of the 1951 meeting of the society. For full particulars, address the American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

* * *

Administrative separation of the **California Tuberculosis and Health Association** and the California Heart Association was announced recently. The joint operation of the two organizations was terminated by mutual agreement because of an "increased need for additional funds for medical research and program development in heart disease which the Christmas seal sale alone could not adequately supply without seriously jeopardizing the 46-year-old campaign to stamp out tuberculosis," according to official announcement. The California Heart Association has reestablished direct affiliation with the American Heart Association, and hereafter will conduct its own fund-raising program in California. Under the plan of separation, C.T.H.A. will continue financial support of C.H.A. on a diminishing scale until 1953.

The close relationship between the two groups will be continued. They will continue to use combined facilities, sharing the cost.

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After a number of years of joint operations, **California Physicians' Service** (Blue Shield) and Hospital Service of Southern California (Blue Cross) will terminate their joint operating agreement December 1, 1950.

This decision, made at a recent meeting of the governing boards of the two organizations, means that after December 1 C.P.S. will function throughout the state as an independent physicians' organization—as it has long done in Northern California. The action was taken by C.P.S. and H.S.S.C. in the interest of greater service to the public and improved operating efficiency.

The present status of C.P.S. physician-members is not affected and there will be no change in existing claims or payment procedures. Similarly, the several hundred thousand C.P.S.-Blue Shield members in Southern California may continue their present benefits without change or interruption.

* * *

The American College of Physicians has announced that a limited number of fellowships in medicine will be available from July 1, 1951 to June 30, 1952. These fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The stipend will be from $2,200 to $3,200.

Application forms will be supplied on request to the American College of Physicians, 4200 Pine Street, Philadelphia, 4, Pa., and must be submitted in duplicate not later than October 1, 1950. Announcement of awards will be made in November 1950.

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Pamphlets containing a statement of policy adopted by the American Association of Registration Executives and the Council on Vital Records and Vital Statistics regarding **the confidential nature of birth records** are available in limited number to physicians who request them, according to recent announcement by the Federal Security Agency. The announcement said that copies were being sent to all local medical groups.

Single copies may be obtained by addressing Halbert L. Dunn, M.D., National Office of Vital Statistics, Washington, 25, D. C.

BOOK REVIEWS

ELECTROCARDIOGRAPHY—Fundamentals and Clinical Application. By Louis Wolff, M.D., Associate in Medicine, Harvard Medical School. W. B. Saunders Company, Philadelphia, 1950.

This relatively brief book on electrocardiography is a very clear and concise discussion of the present concepts of the subject. In brief but adequate manner the author has outlined the basic principles of the electrical phenomena associated with muscle contraction. The first few chapters discuss the dipole theory, volume conductors, intrinsicoid deflections, vectors, primary and secondary T wave changes and in general prepare the reader to approach electrocardiography from the physiologic, rather than the empiric point of view.

In the section on clinical electrocardiography there is an excellent balance and restraint, and the author very properly cautions against diagnosis without adequate evidence. He discusses electrocardiography perhaps too simply, in that only the well-developed patterns are described. The large mass of early patterns and developing patterns is inadequately discussed.

A few sections in which the reviewer disagrees with the author may be cited:

On page 88 the author gives a figure of 0.02 seconds as the maximum intrinsicoid deflection in V_1 and 0.035 seconds as the maximum in V_6. These upper limits are too short and should be increased to 0.035 for V_1 and 0.05 for V_6. On page 89 the author states that the normal QRS interval usually does not exceed 0.08 seconds. Most electrocardiographers would certainly admit that many normal subjects have QRS intervals exceeding this figure.

The problem of incomplete right bundle branch block is not clearly discussed. At times the author states that the presence of R′ in V_1 is unimportant as long as the QRS is within normal limits; at other times he suggests incomplete right bundle branch block. Of course, there is no fundamental agreement even among electrocardiographers on this point. On page 96, in the discussion of bundle branch block, the author states that "Q waves in left ventricular curves of right bundle branch block probably indicate disease of the I-V septum." He does not clearly indicate, as has been shown by Wilson and his co-workers, that the presence of a Q wave in left precordial leads in a record resembling left bundle branch block is usually associated with myocardial infarction. In Figure 41 the interpretation is given as "left ventricular hypertrophy," but the deeply inverted T wave in AVF in association with a horizontal heart should make one wonder about posterior infarction, and esophageal leads would have been helpful.

In the discussion of left ventricular hypertrophy the author tabulates "Q waves common in V_6" as one of the signs of left ventricular hypertrophy (page 109). He does not clearly state that Q waves are also common in normals.

In the discussion on right ventricular hypertrophy (page 119) the author states that diagnostic is the fact that the intrinsic deflection occurs later in V_1 than in V_6. This is misleading and not always true. The intrinsic deflection is usually delayed in V_1 but does not necessarily occur later than that in V_6. In Figure 53 a diagnosis of right ventricular hypertrophy was made on the basis of a deep S in V_6. The author did not discuss the possibility that the transitional zone was displaced further to the left in V_6 in view of the normal appearing QRS complex in AVF, in the presence of a vertical heart. The record suggests incomplete right bundle branch block.

In the section on coronary heart disease, the only criticism is the fact that the author is unwilling to make a diagnosis of myocardial infarction on serial T wave changes. In Figures 59 and 60 for example, progressive T wave changes of characteristic contour without significant QRS changes were described. While it is true that one should hesitate to make a diagnosis of myocardial infarction in the absence of QRS changes, one should be prepared to make the diagnosis when the typical evolutionary waxing and waning occurs with T waves of typical contour.

In the section on pericarditis most electrocardiographers would disagree with the author that Figure 96 is due to acute pericarditis and not due to myocardial infarction. The clinical fact that the patient had repetitive episodes of constricting chest pain over an 18-month period is also very difficult to explain on the basis of pericarditis.

In the section on pulmonary embolism, the changes shown in Figure 97 are too minor to be described as diagnostic of cor pulmonale. The illustrations of Figures 98-101 are much more representative and Figure 97 should be deleted.

Despite the above points of difference, Wolff's book is an excellent elementary text for the student, general practitioner or internist who is not familiar with unipolar leads and the modern electrophysiological concepts of electrocardiography. The clarity, style and excellence of the illustrations make the book easily readable. The book can be highly recommended.

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1949 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY. Edited by J. P. Greenhill, M.D. The Year Book Publishers, Inc. $4.50.

No treatise on obstetrics and gynecology can give the practicing physician a more complete summary of what is new and what is effective than the 1949 Year Book edited by J. P. Greenhill, M.D. The comments are fair criticism and offer evidence that personal opinions alone are not expressed in these interesting paragraphs.

The ability to summarize the many long articles which have appeared during the year makes the Year Book a ready reference to the latest and best.

The discussions of erythroblastosis, genital prolapse and the problems of malignancy deserve special mention. Endocrinology is again presented in a sensible and complete review without the unwarranted enthusiasm of many of the authors. Again, Greenhill's book can be recommended as the review of reviews in obstetrics and gynecology.

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A STORY OF NUTRITIONAL RESEARCH—The Effect of Some Dietary Factors on Bones and the Nervous System. By Sir Edward Mellanby, G.B.E., M.D., Sc.D., Secretary of the British Medical Research Council. The Williams and Wilkins Company, Baltimore, 1950. $5.00.

Mellanby's Flexner Lectures, delivered at Vanderbilt University, constitute a ponderous story of one aspect of the problem of research in nutrition, namely the rachitogenic features of certain artificial diets. The volume presents a detailed protocol of experimental work dealing with the effects upon the nervous system and the osseous system of the accessory food factors, vitamin A, calcium, phosphorus, phytic acid, phytase and the anticalcifying substance in cereals. The problem of vitamin A deficiency and its relation to nerve degeneration and muscular incoordination in laboratory animals (rabbits, dogs, ferrets, rats, chickens,

etc.) is clearly presented, and although the neurologic lesions are definitive under circumstances of rigidly controlled dietetic restrictions, similar changes occurring in the human subject are hardly possible because of the myriad protective effects of other substances taken in the mixed diet. The possible exceptions to the above are xerophthalmia and hemeralopia, which may occur with relatively minor vitamin A deficiencies. Mellanby has also shown that there is an associated osseous dysplasia (bone overgrowth) around the central nervous system structures in vitamin A deficiencies.

Part II of the volume deals with the anticalcifying or rachitogenic action of cereals. The experimental evidence for the anticalcifying effect of phytic acid and the protective effects of vitamin D are well presented. Although this book may be of value to workers in the field of research in nutrition, the volume is of limited used to the physician, as it deals with a subject which is still in a controversial state.

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QUINIDINE IN DISORDERS OF THE HEART. By Harry Gold, M.D., Professor of Clinical Pharmacology, Cornell University Medical College, Paul B. Hoeber, Inc., New York, 1950. $2.00.

Gold's monograph of 100 pages is the first book dealing solely with the use of the important drug quinidine. The author has followed a uniform plan and has discussed in turn the details of indications, therapeutic actions, toxic actions, effect on the electrocardiogram, clinical pharmacology, dosage, and the prevention and treatment of all the minor and major arrhythmias with which the practitioner may be presented. There is a very brief discussion of quinidine in children and of alternative routes of administration, and a chapter on combined use of quinidine and digitalis. The section on pharmacology of the drug is clear and concise, as would be expected from the special qualifications which the author has in this field. The reviewer strongly concurs in Gold's statement that "the use of inflexible systems of dosage is responsible for a large share of the defeats in quinidine therapy, and some of the disasters." Gold indicates, but does not emphasize as clearly, that the disasters are often due as much to failure of careful supervision, with repeated clinical and electrocardiographic observations during and after conversion of an arrhythmia, as to the inflexibility of the system of dosage.

The major criticism that the reviewer has of the monograph concerns Gold's handling of the chapter on chronic auricular fibrillation. Many cardiologists would disagree with his statement (on page 53) that the use of quinidine in long-standing auricular fibrillation has, for the most part, been abandoned. He admits that quinidine is blamed for accidents which are purely coincidental, yet stresses the fact of occasional serious complications of quinidine therapy without giving sufficient emphasis to the hazards of auricular fibrillation per se, and to the benefits that may be obtained by converting some patients with auricular fibrillation to normal rhythm.

One might question the author's recommendation to avoid the simultaneous use of quinidine and digitalis whenever possible. His stress on the toxicity of quinidine in animals poisoned with digitalis does not do justice to the clinical fact that the two drugs have been repeatedly used in combination without difficulty when poisoning with either drug is avoided. If quinidine is used without prior digitalization in patients with auricular fibrillation, acceleration of the ventricular rate with quinidine may be so great as to force cessation of quinidine therapy.

With the reservations noted in the discussion of chronic auricular fibrillation and of the combined use of digitalis and quinidine, this monograph can be strongly recommended to the practitioner as an excellent guide to the understanding and successful use of quinidine.

DIFFERENTIAL DIAGNOSIS OF CHEST DISEASES. By Jacob Jesse Singer, M.D., Medical Director of the Rose Lampert Graff Foundation, Beverly Hills. Lea & Febiger, Philadelphia, 1949. $7.50.

This book appears to be somewhat unbalanced. For example, coccidioidomycosis is given one-fourth of a page with no mention of the generally accepted diagnostic procedures, while there is a complete chapter on hydatid cyst of the lung and another chapter on lipoid pneumonia.

The title of the book excludes therapeutic considerations, which will greatly curtail the value of this volume to many physicians. However, the author is inconsistent in devoting considerable space to surgical treatment of pulmonary tuberculosis. Insufficient consideration is given to the modern bacteriologic methods of diagnosing pulmonary tuberculosis. Too much emphasis is placed upon bronchoscopy as a diagnostic procedure in bronchiectasis, and so important a disease as pulmonary embolism is neglected.

* * *

HORMONES IN CLINICAL PRACTICE. By H. E. Nieburgs, M.D., Research Associate Department of Endocrinology, Assistant Professor, Department of Oncology, University of Georgia. Paul B. Hoeber, Inc., New York, N. Y., 1950. $5.50.

The author of this book is a research endocrinologist who originally worked in England and who is now at the University of Georgia in this country. His style and interpretations show characteristics of training in endocrinology on both sides of the Atlantic.

In the general format of the book, separate chapters are devoted to the hormones of a given gland of internal secretion. Each one starts with a rather extensive discussion of the physiology and then proceeds directly to a list of the preparations available for clinical use, with the indications for them, and the dosage. Generally there is little or no discussion of the pathology, or clinical descriptions of the various endocrine diseases—as is indicated by the title of the book. While this has allowed the author to be more complete in the material he does cover, it also narrows the range of usefulness of the book as a reference work for the ordinary practicing physician.

There are also chapters on the pineal and thymus glands, on psychosomatic endocrinology, on non-hormonal substances used in endocrinology, and on vitamin-hormone relationships. They are short, and represent principally the collection and discussion of some bibliography on these subjects.

Toward the end of the book is an extensive chapter on endocrine diagnostic procedures. These are well described, but one has the impression that the compilation is not quite up to date. For instance, 11 pregnancy tests are listed, but the recent test using male frogs and toads which is now coming into considerable acceptance is not included. The count of circulating eosinophils now widely used by endocrinologists in estimating adrenal cortical function also is not mentioned.

Finally, a list of commercial preparations is appended. Although the author makes no claims for completeness, it is an extensive list, and may be of some help. One example of an apparent omission is the lack of distinction between the types of methyl testosterone that are prepared to be swallowed or to be administered sublingually or for buccal absorption. It is always difficult to keep such a list up to date.

The book is an admirable piece of work, but some criticism seems indicated by the following observations: In the physiological sections, there are occasional quite dogmatic statements regarding matters which are still in a state of discussion in many laboratories and are not generally accepted as having been proven. Various preparations are listed, with dosage, etc., which have very little clinical application. These are listed with the more generally used

and more effective preparations without any critical discussion to indicate relative values. The physician without special training or experience could well be led astray. An extensive bibliography is given at the end of each chapter, but unfortunately a few errors are apparent. The discussion on antithyroid substances is principally on thiouracil. Very little space is given to propylthiouracil which is now acknowledged to be considerably safer and more effective and is much more generally used. The data that are given seem to have been added as an afterthought.

The recent work on ACTH and Compound E in arthritis and other diseases is not mentioned.

In general, the book is interesting reading for an endocrinologist and would be an addition to the library of anyone particularly interested in this field. Its value to the practicing physician without training and experience in endocrinology is doubtful.

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AIR POLLUTION IN DONORA, PA. Epidemiology of the Unusual Smog Episode of October, 1948. Preliminary Report. Public Health Bulletin No. 306. Federal Security Agency. Public Health Service, 1949.

In October 1948 the small mill town of Donora, Pennsylvania, was smothered for three days with unprecedented smog. Twenty persons allegedly died as a result of the pollutants in the atmosphere and some several hundred more were affected. Various agencies were called into the area to study the cause and effect of the smog, among which was the United States Public Health Service. Public Health Bulletin No. 306 is the published data of a five-month study by this group.

This exceedingly attractive publication is about the size of *Fortune*. There are short introductions, etc., by Oscar Ewing, administrator of the United States Public Health Service, as well as by Surgeon General Leonard A. Scheele, James G. Townsend, chief, Division of Industrial Hygiene, and his assistant, J. J. Bloomfield. Some 37 individuals have contributed to the research activities, as well as to the publication of the bulletin.

Bulletin 306 is well illustrated with photographs, reproductions of chest films, microphotographs of pathological slides, drawings, graphs, tables, etc. The work is divided into the following: (1) Introduction, (2) Biological Studies, (3) Atmospheric Studies, (4) Discussion of Cause of the Episode and (5) Summary and Recommendations. Certain members of the team were assigned to a community and house-to-house survey in which the inhabitants were questioned as to their reactions at the time of the smog episode. The practical application of such a statistical study is to be questioned.

Unfortunately, no samples of the air were obtained during the episode, so that the concentration of contaminants in the atmosphere at that time could not be determined. Later studies of the industrial operations and stack output in the valley indicated that the single most significant material polluting the air was sulfur dioxide. It was felt, however, that "it was doubtful that either sulfur dioxide or sulfur trioxide, acting individually or together, reached levels that were capable of producing the syndrome."

Over 90 per cent of the persons affected complained of upper or lower respiratory symptoms. Most of the severe cases and all of the deaths occurred in the older age groups, among individuals with preexisting pulmonary or cardiac pathology. Autopsied cases showed acute pathology primarily in the "terminal bronchi, the bronchioles and the pulmonary parenchyma."

It is the opinion of the United States Public Health Service that "while no single substance was responsible for the October 1948 episode, the syndrome could have been produced by a combination, or summation of the action, of two or more of the contaminants."

HANDBOOK OF DIGESTIVE DISEASES. By John L. Kantor, M.D., Late Associate Professor of Medicine, and Anthony M. Kasich, M.D., Lecturer in Medicine, both at Columbia University. Second Edition. Illustrated. The C. V. Mosby Company, St. Louis, 1949. $11.00.

Dr. Kasich has done a commendable job of enlarging and bringing up to date Dr. Kantor's earlier, smaller "Synopsis of Digestive Diseases." The result is a practical, clinical volume in which the disease entities are separated in the usual textbook fashion. The illustrations are numerous and to the point. The approach to the subject is from a sound physiological point of view. The fundamental aspects of digestive diseases are presented concisely.

The book gives the general practitioner, surgeon, or internist a good source of up-to-date information on gastrointestinal diseases — better and more pointed than that which he will find in a general text on the practice of medicine. It is highly recommended.

* * *

BRUCELLOSIS (UNDULANT FEVER) Clinical and Subclinical. By Harold J. Harris, M.D., F.A.C.P., with the assistance of Blanche L. Stevenson, R.N. Second Edition, Revised and Enlarged. Paul B. Hoeber, Inc., 1950. $10.00.

This handsome monograph of some 600 pages tells about all there is to know on the subject of brucellosis. History, etiology, pathology, the various clinical features of acute and chronic brucellosis, are all thoroughly discussed. Under therapy even the recent results with aureomycin are included. There are many good illustrations, a large bibliography and an index. The volume does not lend itself to detailed review but seems definitive to date as a reference work.

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NUTRITIONAL DATA. Compiled by Harold A. Wooster, Jr., and Fred C. Blanck. Published by the H. J. Heinz Company, P. O. Box 57, Pittsburgh, Pa.

This brochure, which may be had gratis for the asking, is a truly remarkable compendium and collection of the important data on dietetics, nutrition and the biochemistry of food and food products. It contains an excellent epitome of the vitamins, including the signs and symptoms of their deficiency, and their dietary sources. The text dealing with the essential mineral elements is the most comprehensive and intelligible presentation of the subject available. The dietary sources of the mineral-rich foods makes this section unusually practical.

The section dealing with the essential amino acids is amazingly well presented and terse. The material is condensed in the form of tables which epitomize those foods rich in the essential amino acids. There is a short section which deals with the practical chemical tests for the detection of malnutrition, which is followed by tables indicating the cardinal features of nutritional anemias, and deficiency diseases of the epithelium. For the person trained in biochemistry, the latest information concerning the intermediate metabolism of the carbohydrates, fats, and nitrogen compounds is given along with a discussion of the enzymes involved in digestion. The last half of the volume contains charts of the recommended daily dietary requirements followed by a synoptic section dealing with diet in health and disease.

One of the most valuable features of the volume is the extensive collection of tables giving the composition and the nutritive value of foods according to dietetic groupings. This section is invaluable to the practicing physician. And for those who wish to use prepared or canned foods, there is appended the analysis of all available products of the Heinz Company. The volume is highly recommended as a valuable addition to the physician's ready reference library.